THE AMERICAN JOURNAL of OCCUPATIONAL THERAPY

OFFICIAL PUBLICATION OF THE AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

Vol. VII No. 5 | 1953 | September-October

TABLE *of* CONTENTS

ARTICLES

DIVISIONS

FEATURES

the happy medium

Colors are so sparkling, flow so smoothly, blend and intermix in such endless variety that impressive effects are produced spontaneously, leading the student unconsciously into further exploration. Suggestions for use are contained in an ARTISTA Water Colors folder. For *free* copy, send to Dept. JO-10

BINNEY & SMITH CO.

New York 17, New York • *Celebrating 50 Years of CRAYOLA® Leadership*

The American Journal of Occupational Therapy

The Official Publication of the

American Occupational Therapy Association

33 West 42nd Street, New York 36, N.Y.
Executive Director, Marjorie Fish, O.T.R.

The Journal is published bimonthly on the 10th of February, April, June, August, October and December by the North Shore Publishing Company, 3514 N. Oakland Ave., Milwaukee 11, Wisconsin, for the American Occupational Therapy Association.

Subscription price to members included in yearly fees; to non-members $5.00 a year domestic, $5.50 foreign. Single issues, $1.00.

Change of address notices should include the old as well as the new address, postal zone, and should be mailed six weeks in advance of publication date.

Original contributions submitted for publication in the American Journal of Occupational Therapy are for exclusive publication and may not be published elsewhere.

Opinions and statements expressed in the magazine are those of the authors of articles and are not to be considered as representing the views of the American Occupational Therapy Association.

Rates for display advertising furnished on request of the Editor. Classified advertising accepted only for Situations Wanted and Positions Available.

Correspondence of an editorial nature should be addressed to the Editor, Mrs. Lucie Spence Murphy, O.T.R. Change of address and matters pertaining to circulation should be mailed to the A.O.T.A. office.

Entered as second class matter at Post Office, Milwaukee, Wisconsin, under the act of March 3, 1879.

The Road to Recovery can Start with Rug-Making!

Shillcraft Rugs . . A Pleasure to Make . . A Treasure to Own!

Rug-making the modern Shillcraft way develops amazing agility, coordination and sureness with hands. Anyone who can move their hands can become an expert after only a few minutes. Delightful, non-tiring hobby . . . relaxing, soul-satisfying work. Patients are well "on the road back" to health and happiness when they see the beautiful rug patterns coming to life in gorgeous, glowing strands of wool beneath their very own fingers. When finished these luxurious, deep-pile 100% wool rugs are something to be proud of . . . beautiful enough for the finest homes. Each Shillcraft Rug Outfit contains EVERYTHING required to make a complete rug . . . including sturdy canvas with rug design stencilled in full colors . . . patented Latchet Hook . . . pre-cut to size rug wool . . . and instructions. Mail coupon for illustrated Rug Book.

SEND FOR *Shillcraft* Readicut RUG BOOK

69 Rug Designs [99 Sizes] In Full Rich Colors!

Nothing else like it in America! Our wonderful full-color 24-page Rug Book is packed with gorgeous rug designs and valuable step - by - step illustrations. Even children (of 8 or 9 years) can make these lovely rugs.

SHILLCRAFT RUGS MAKE WONDERFUL GIFTS!

Amazing!

No Bulky Frame Needed!

No Experience Necessary!

Easiest rug-making method ever known! Shillcraft 100% Virgin Wool comes PRE-CUT in correct length, ready to use (no winding or trimming required). With the patented Latchet Hook the yarn is tied securely to the sturdy English canvas. Will not ravel or pull-out; can be vacuumed with complete safety.

MAIL COUPON TODAY

Buy Direct From Importer At Great Savings! Mail Coupon Now!

Complete information and direct from importer prices sent with our Rug Book. Shows how EASY and INEXPENSIVE it is to make Shillcraft Readicut Rugs that will be cherished for years. The finished rugs are worth many, many times the cost of material.

Shillcraft **Dept. AJ-1, 106 Hopkins Place Baltimore-1, Md.**

Please send me your Shillcraft Readicut Rug Book, showing 69 designs (99 sizes) . . . in full-color, in modern and traditional patterns; in rectangular, oval, round and semi-circular shapes. I enclose 25c (in coin) to cover handling costs.

NAME . . . .

PLEASE PRINT

ADDRESS . . . .

CITY . . . . **ZONE** . . **STATE** . . . .

Sorry, not available to Canada at this time.

THE AMERICAN JOURNAL
of
OCCUPATIONAL THERAPY

Official Publication of the American Occupational Therapy Association

September-October 1953 VOL. VII, No. 5

FEEDING SUGGESTIONS FOR THE TRAINING OF THE CEREBRAL PALSIED

FOREWORD: To exchange ideas and discuss their therapy problems in relation to the cerebral palsied, the occupational therapists in and around New York City have been meeting bi-monthly. This paper is the result of their combined thinking about the problem of feeding training. The occupational therapists represented the following clinics:

Bergen County Cerebral Palsy Center, Ridgewood, New Jersey.

Blythedale Rehabilitation Hospital, Valhalla, New York.

Branch Brook Public School for the Handicapped, Newark, N. J.

Columbia University School of Occupational Therapy, New York City.

Co-ordinating Council for Cerebral Palsy, New York City.

Essex County Cerebral Palsy Center, Newark, New Jersey.

House of St. Giles the Cripple, Garden City, Long Island, N. Y.

Hospital for Special Surgery Cerebral Palsy Clinic, New York City.

Institute for the Crippled and Disabled, New York City.

Institute of Physical Medicine and Rehabilitation, New York City.

Lenox Hill Hospital Cerebral Palsy Clinic, New York City.

New York State Rehabilitation Hospital, Cerebral Palsy Center, West Haverstraw, New York.

Passaic County Cerebral Palsy Center, Clifton, New Jersey.

Public School No. 85 Bronx, New York City.

Public School No. 135 Manhattan, New York City.

Public School No. 118 Queens, New York City.

Vanderbilt Cerebral Palsy Clinic, Columbia-Presbyterian Medical Center, New York City.

Westchester Cerebral Palsy Association, Bedford Hills, New York.

INTRODUCTION

Since everyone must eat to survive and since feeding, in a high percentage of cerebral palsy individuals, is difficult for both the child and the parent, it should be one of the first activities checked by the occupational therapist before planning a treatment program. Feeding difficulties may range from messy feeding through the inability to voluntarily control chewing and swallowing. Between these two extremes will be all gradations of ability and individual differences. In addition to dependence on the parent, there may arise psychological problems due to the inability to perform a normal activity in the presence of others. Every child should be taught to eat as well as his capacity will allow. This does not mean that feeding training should be limited to the child, but if training is instituted during childhood, much social maladjustment can be avoided.

PLANNING THE PROGRAM

In suggesting a program for feeding training, the therapist should be aware of the child's mental and motor capabilities. The Arnold Gesell Developmental Scale is a big help in planning a progressive program because it gives the motor ages required for the complicated motions of feeding. To assure the co-operation of the parent it is of prime importance that the initial home program be practical and answer the parent's immediate needs. Too often the plan of training is too advanced for the individual to either understand or to master. The first objectives should be simple and easy to carry out so that success will be inevitable. Parents must recognize and appreciate the importance of short term goals in relation to their child's becoming more independent in feeding. The following questions when answered may help the therapist develop an adequate program:

1. How has the child been fed?
2. How does he hold his head?
3. Is there a swallowing difficulty—as a result of this is he on a semi-solid diet?
4. How does he suck, sip or drink liquids?
5. Does he drool?
6. How does he bite and chew?
7. How does he use his tongue?
8. What kind of dish, straw, cup, spoon or fork has been used?

9. Are there interfering motions of his head, hands or feet?
10. What attempts has he made to feed himself? How does he grasp a cookie, spoon, fork or cup? Does he get food to his mouth or into his mouth?
11. What has been the attitude towards the whole process of eating? Is he motivated or discouraged with feeding?
12. What kind of appetite does he have? What conditions has the mother found most satisfactory?

After carefully analyzing the situation, the therapist is now ready to outline a feeding plan to meet the current needs of the individual. The problem may be due to: (1) a lack of physical control or poor posture, (2) inability to suck, chew or swallow, (3) bad habits, lack of interest and negativism, (4) retarded mentality with inability to use the maximum physical potential, or (5) a lack of adequate equipment.

All feeding training begins with the mother feeding the baby. Her technique and attitude are most important. Because a child cannot feed himself, he should not be segregated from the rest of the family at meal time. Such continued isolation hinders the social development of the cerebral palsied just as it would that of a normal child. The child may be fed earlier and only sit with the family during meal time or he may be able to eat dessert or a cookie with the group. He should be made to feel a part of the family and be accepted by them. Avoid constant nagging which only adds to the already existing emotional problems concerning feeding. The mother can delay progress by prolonging the infant swallowing pattern with spoon feeding to the back of the mouth while she continues to hold the child in a half-reclining position. At this initial stage of feeding the therapist can aid the parent in establishing a proper position of holding her child and special feeding techniques: i.e., lip closure and swallowing. To be effective, feeding training should be a pleasant experience and be done when the child is most co-operative. Each mother will know which time to choose.

The child should be held in an upright position with a minimum of support from the parent. He should be taught to hold his head in a slightly downward position which is the normal head position during eating. The spoon should be placed between the lips allowing him to close his lips over the spoon and to remove the food with his upper lip. Care should be taken by the parent to put the spoon on the tongue with some downward pressure to eliminate the tendency to push the food out of the mouth with the tongue as many cerebral palsied children do. Never put the entire bowl of the spoon inside the dental arch; this precaution will eliminate the child's tendency to close his teeth on the spoon handle which would prevent him from using his upper lip to remove the food from the spoon. If there is any fear of the child hurting himself on a metal spoon, a wooden, plastic or rubber-coated spoon may be used. To give the child the feeling and understanding of lip closure, the parent may give some pressure on the lips. To assist swallowing the parent may stroke the throat lightly.

In conjunction with teaching the parent these initial steps in feeding the child, the therapist should stress the importance of seating the child in a straight chair as soon as possible. The first thing to consider is his sitting position and head balance. The table and chair should meet the needs of the individual so that his elbows are even with the top of the table and his feet are placed flat on the floor or are supported. For the severely handicapped, a cut-out table will offer more security. The height of the seat of the chair depends on the distance between the sole of the child's foot and his flexed knee; the depth of the chair seat is measured from the crease of the flexed knee to the back of the buttocks. The width is taken across his hips with an allowance made for braces when necessary. The back of the chair should be perpendicular to the floor. With the severely handicapped child it may be necessary to use binders or other additional supports (sandbags, head pads or rests, arm or leg restrainers to help him maintain his sitting position); nevertheless, it is wise to keep these additions at a minimum, thus approximating normal conditions.

REQUIREMENTS

Before beginning self-feeding the child should have the following physical capabilities:

1. Sitting and head balance.
2. Ability to remove food from the spoon with his lips.
3. Ability to bite, chew and swallow with a minimum of drooling.
4. Sip and take liquids from a cup.
5. Grasp without help.
6. Ability to bring his hand to his mouth.
7. Have eye-to-hand coordination.

Although the child does need these pre-skills in learning to feed himself, it is not necessary that all seven be completely mastered. However he should be making some attempt at all seven. In order to achieve adequate results it is important that parents, speech and occupational therapists plan together a co-ordinated well defined feeding program utilizing all methods of teaching mouth control. Biting, chewing, swallowing and lip movements are as essential for developing speech as for eating.

While feeding the child the parent can aim toward the above mentioned capabilities by:

1. Sitting the child upright in a straight chair at a cut-out table if necessary, with his forearms

resting on the table top (arms restrained when indicated.)

2. The parent holding the spoon level with the child's mouth and the child bringing his head forward to remove the food from the spoon with his lips.
3. Encouraging the child to chew his food and swallow it with his mouth closed.
4. The parent holding the cup level with the child's mouth, cup on top of the tongue and slightly behind the teeth; child sips liquid, swallows and sips again. Too often the liquid is poured down the throat and the child gulps it rapidly, sometimes choking.

5-6. At the end of the meal, letting the child take hold of his bib and wipe his mouth; help him if necessary.

7. It is important for the child to realize what he is doing. The cerebral palsied child rarely learns by accident; he learns by knowing what his needs are and how to fulfill them, and by concentrating on specific instructions.

Before the severely handicapped child can attempt any form of self-feeding he may require long hours of practice (not at one time) to gain relaxation of his head and neck, and adequate shoulder and arm control. Should this be evident, teaching the child to drink liquids through a plastic straw may be the initial step toward his achieving some independence. Here prerequisites include adequate lip and tongue control and a good sipping and swallowing pattern. Having mastered these the child can be taught to sip liquids through a plastic straw. For home use a plastic refrigerator cup and cover plus the straw can be utilized. Weaning the child away from complete dependence on adult care not only aids him in becoming more self-sufficient but helps free the adult from this time consuming task.

The following steps are suggested for progression in self-feeding, (the parent may sit in front or beside the child during training, but should not stand and lean over him):

1. Child can bring his fingers to his mouth—jam or the like on fingers.
2. Hold food and take it unassisted to his mouth—swieback or frankfurters (the latter may be helpful to athetoids who would tend to jab mouth).
3. Child picks up spoon or fork from the table without help.
4. Child brings spoon or fork to mouth—parent fills it with jam, cream cheese or the like.
5. Child fills spoon or spears food with fork without help—sticky food stays on more easily.
6. Child picks up and releases spoon or fork as needed.
7. Child grasps cup and drinks from it unassisted.
8. Work for easy use of spoon or fork and a good appearance (to the onlooker). A mirror may help by letting him see for himself what needs improving.
9. After doing well, go on to using a knife for spreading and cutting.

Each therapist may use toys or crafts to aid in teaching desired hand motions, thus increasing the practice of motions used for feeding. There are many methods of teaching drinking, chewing and swallowing; the best method is that one which suits the individual and brings about his continued improvement.

SUGGESTIONS FOR FEEDING TRAINING

Foods

1. To teach the child to bring his hand to his mouth:

For finger licking use whatever the child likes, remembering that most children like to help lick a bowl emptied of whipping cream, sweetened egg whites, cake batter or frosting. Wipe the bowl with the child's hand and let him lick his fingers. Cream cheese or jam may also be applied to his fingers to encourage his bringing them to his mouth.

Meat is more easily digested without chewing than raw vegetables. Hot dogs, beef bones (or ones that will not splinter) with a small bit of meat left on them, bread sticks, zwieback or lolly-pops on a paper stick all encourage holding something and bringing it to the mouth. (Refrigeration will keep the candy on the stick during hot weather.)

2. To use for chewing:

Celery mats into a bolus and can be taken from the mouth while carrots crumble and get under the tongue and cannot be removed by the child himself. Green beans or carrots that are partially cooked can still be held in the hand and are easy to chew. Any kind of meat the child likes cut into small pieces can be used to encourage chewing. Zwieback or toast will dissolve easily if not well masticated. Some doctors will permit the use of marshmallows, gumdrops or caramels which are all fine for both tongue control and chewing. Bubble gum has a more leathery consistency than ordinary gum. A gauze or teabag with the gum inside and attached to a string may be attempted if there is any fear that the child might swallow or choke on the gum. The gum inside the bag may be softened in warm water before putting it into the child's mouth, it can easily be withdrawn from the mouth when the training period is finished.

3. For using a fork or spoon:

Any food that will easily stick to the implement: cream cheese can be colored or flavored to suit the child's taste; cooked cereals or rice pudding; jam (without seeds); mashed potatoes or other vegetables of that consistency; junior baby foods; sauces thickened with crackers or bread; desserts like prune whip, mashed bananas or instant pudding. (Amazo Instant Dessert and Burnetts Instant Pudding can be made by adding cold milk to the powder and the thickness adjusted to the needs of the child. Another advantage is that one serving can be made without wasting the rest of the powder.)

For spearing with a fork, smooth peanut butter on bread or thickly sliced meat works well.

Bibs

All bibs should be large enough to cover the child and be made of an absorbent material so that the food does not dribble off onto the clothes. Plastic bibs are often too hot to wear in the summer. Perforated plastic bibs with Drypers inserted (in an underside pocket) have been used with success. Toweling made into a bib with an elastic opening so that the child can pull it over his head without help has also been successful. Caution should be taken in letting him pull off such a bib because if it is wet or sticky he will probably transfer that to his face or hair unless he has good hand use and coordination.

Dishes

DESCRIPTION	MANUFACTURER	COST	COMMENTS
Plastic baby bowl (Dr. Slater Dishes)	W. F. Dougherty & Son 1009 Arch St.		Heavy weight, shallow bowls and rims
Dee Scoop Eating Set (dish and curved bowl spoon—either for right or left hand)	Givens & Co. 1-2-3 Lullabye Lane Downers Grove, Ill.	$3.95	The imperfect dish at $1.50, plus 33c postage, sold especially for C.P.'s. Dish can be weighted with plaster of paris mold; add 7/8" diameter rubber bumpers to make it slip proof.
Plastic baby bowl, three suction cups on base	DiFiore Co. Chicago, Ill. (or Five & Dime) or Mr. Irving Belcher Baby World Co., Inc. 36-32 34th St. Long Island City 6, N.Y.	$ .79 $ .50	Suction cups will only stick on a smooth surface
Grip-tite bowl with double suction cup	Sold in baby depts. and Five & Dime		Double suction does not hold as well as above dish with three suction cups
Metal dish with suction cups	Montgomery Ward	$1.39	Dish is shallow
Suction cups to attach	Gordon Mfg. Co. 110 E. 23rd St. New York, N.Y.		

Methods of stabilizing dishes:

1. To make a plaster mold for Dee Scoop Dish, pour plaster of paris into underneath side of dish (nothing needs to be spread on dish before pouring plaster). Before plaster hardens, place 7/8" diameter rubber bumper (sold for toilet seats) in each corner. When the plaster is thoroughly dry remove from the dish. May be painted or shellacked.
2. Rubber mat placed under dish.
3. Clay on the bottom of the dish and adhering to the table.
4. Suction cups attached to bottom of dish (Gordon Mfg. Co.)
5. Cut-out board, with openings to fit dish, clamped to the table.
6. Wet turkish towel wedged around dish—as sailors do during stormy weather.

Straws

DESCRIPTION	MANUFACTURER	COST	COMMENTS
Extrunded Tygon plastic (diameter to 2 1/2")	U. S. Stoneware Co. Tallmadge Square Akron 9, Ohio		Soft plastic tubing making a nice flexible straw
Poly-ethylene tubing (slightly stiffer than above)	Prince Rubber Co., Inc. 889 Niagara St. Buffalo 13, N.Y.		

DESCRIPTION	MANUFACTURER	COST	COMMENTS
Plastic tubing	Electrical supply Aquarium supply Chemical supply Five & Dime Anchora Aquarium 395 E. 71st St. New York 21, N.Y.		15c a foot; will mail anywhere in U.S.
Hard plastic straws	Five & Dime	.10 for six	May be bent under hot water
Hard plastic straws with a mouth piece	Art Button Novelty Co. 12 E. 22nd St. New York 10, N.Y.	$2.85 a gross	
Paper straws with slight angle (cellophane)	Hospital supply		
Tongue blades with candied tip (Pedi-treat)	Marvin R. Thompson, Inc. Stamford, Conn.		Excellent for motivation
Candy straws or licorice tubes	Local candy supply		Excellent for motivation

Spoons and Forks

DESCRIPTION	MANUFACTURER	COST	COMMENTS
Spoon with DeeScoop eating dish has a curved bowl turning toward mouth		$1.50	Only right handed ones come with dish but left handed ones can be ordered
Adapted spoons and forks with curved bowls	National Silver Co. 295 Fifth Ave. New York, N.Y. or Janard Therapy Co. 60 E. 42nd St. New York 17, N.Y.	$ .85 Two for $1.15	Regular sized silverware with large adapted handles. Too large for small children
Spoon and fork (Sterling silver)	Craig Merrill 392 Gilbert St. Ridgewood, N.J.	$7.00 a set	Curved bowl, hook on handle to prevent slipping into dish. Easy to pick up from table
Child's set of silver (stainless steel with plastic handles, 3 pieces)	James Household Plastic West Orange, N.J.	$1.98 a set	Can be easily curved to meet child's needs.
Swivel spoon (Sta-level Training Spoon)	Price Industries, Ltd. 309 Main St. Akron 8, Ohio	$1.25	Has not been found too successful with athetoids (just another moveable joint). Works with some children

Cups

DESCRIPTION	MANUFACTURER	COST	COMMENTS
Tommee Tippee cup (weighted bottom, bell-shaped with lid)	Westland Plastics, Inc. 833 E. 31st St. Los Angeles 11, Calif.	$1.00	Very good—heavy

DESCRIPTION	MANUFACTURER	COST	COMMENTS
Baby Sandy cup (metal cup with lid)	W. A. Genesy & Co. 828 S. Los Angeles St. Los Angeles, Calif.		Lid not too secure for involuntary motions
Baby training cup with lid (spill proof tumbler weaning glass)	Avalon Products Hillman, Mich.	$ .59	Works well with many small children (can be purchased with baby food labels). Plastic handles can be added
Styrene Wonderflo cup (closed cup with protruding straw	Styrene Wonderflo Co. Service Products Spring St. Atlanta, Ga.	$1.00	Good for beginning sucking
Two handled plastic cup with or without lid	Five & Dime	$ .59	Excellent, as handles are large enough to allow child to grasp with four fingers
Small soft plastic glasses	Housewares depts. Five & Dime		In order to weight cup permanently, fill half full of plaster of paris. For drinking, use a paper cup placed over plaster. Handles can be made of celastic and attached to plastic glasses.
Plastic or heavy glass cup with handle to get four fingers around—beer mug style	Five & Dime		For teens and adults—weight cuts down overflow
Plastic refrigerator cups with lids. Put hole in lid to hold a straw	Republic Plastic Corp. Chicago, Ill. Five & Dime James Household Plastic West Orange, N.J.		Excellent for home use When ordering specify for a clinic and 15% discount will be given. To order—cups and lids are separate, i.e. 9-oz. tumblers, set of six—$1.09; 9-oz. seals, set of six—$.38. Write for price list. They also have "Measure-well" which forces one spoonful of liquid to top of container.

SELECTED READING

1. Abel, Marjorie, "Feeding the Child with Cerebral Palsy," *American Journal of Nursing*, L, September, 1950, pp. 558-560.
2. Bosley, Elizabeth, "Parents Can Help With Speech," *Spastic Review*, March, 1945, 5:3:6-9
3. ———— "Teaching the Cerebral Palsied to Chew," *Spastic Review*, Feb., 1949, 10:2:7-9-20.
4. Brunyate, Ruth, "Occupational Therapy Means Freedom for Parents," *The Crippled Child*, XXVI, Feb., 1949, pp. 11-13.
5. California, State of, *A Guide for Feeding Children With Cerebral Palsy*, San Francisco, State of Calif., Dept. of Public Health, 1951.
6. Cardwell, Viola, *The Cerebral Palsied Child and His Care in the Home*, Association for the Aid of Crippled Children, New York City, 1947, $1.00.
7. Cass, Marion E., *Speech Habilitation in Cerebral Palsy*, Columbia University Press, New York, 1951.
8. Phelps, Winthrop "Dietary Requirements in Cerebral Palsy," *Journal of American Dietetic Association*, XXVII, Oct., 1951, pp. 869-876.
9. Dillingham, Elizabeth, "Feeding and Dressing Techniques for the Cerebral Palsied," *The Crippled Child*, XXVI, December, 1948, pp. 20-24.
10. Grayson, Elizabeth, "Occupational Therapy for the Cerebral Palsied Baby," *The Crippled Child*, XXVII April, 1950, pp. 6-7.
11. Hadra, Ruth, "Developmental Factors in the Cerebral Palsied Child," *The Crippled Child*, XXVIII, August, 1950, pp. 18-19.
12. Wagner, Elizabeth, "Feeding and Training for the Cerebral Palsied," *Cerebral Palsy Institute Proceedings*, Co-ordinating Council for Cerebral Palsy. Distributed by Association for the Aid of Crippled Children, 580 Fifth Ave., New York City, $1.50.
13. Ward, Moria M., "Etiquette for the Cerebral Palsied Child," *Cerebral Palsy Review*, May, 1952, 13:5:3-4, 11-13.
14. Weiss,, Deso A. and Beebe, Helen H., *The Chewing Approach in Speech and Voice Therapy*, Basil-S. Karger, New York, 1952 (Trans.)
15. Westlake, Harold, "A System of Developing Speech With Cerebral Palsied Children," reprint from the June, August, October and December, 1951, issues. of *The Crippled Child*, National Society for Crippled Children and Adults, 11 S. LaSalle St., Chicago 3, Ill.
16. ————, "Speech Training for the Cerebral Palsied Child," *The Physical Therapy Review*, Feb., 1952, Vol. 32, No. 2, pp. 59-64.
17. National Society for Crippled Children and Adults, Inc., *Cerebral Palsy Equipment Manual*, $5.00.
18. New York University-Bellevue, Institute of Physical Medicine and Rehabilitation, *Self-Help Devices for Rehabilitation*, pamphlet series, 400 East 34th Street, New York, N. Y.

OCCUPATIONAL THERAPY TECHNICS FOR THE PRE-SCHOOL HEMIPLEGIC

Toys and Training

ISABEL PICK ROBINAULT, O.T.R., M.A.
Cerebral Palsy Pre-School Center†
Lenox Hill Hospital

When adults look at a baby with a spastic hemiplegia and see the tight little arm and fist hanging uselessly from the shoulder, they feel sorry for the disabled child. However the child, who has felt no need for what he has never used, becomes irritated when adults break into his contentment and attempt to make him use this useless extremity. As a result an emotional problem may be added to the physical one. In fact an alert child may so dissociate himself from his hanging arm as to invent hand-mouth or hand-knee bilateral compensations and may manage very well during his first three years of life, prior to the need for skilled activities. The objectives for a rehabilitation program for children are (a) to prevent deformities, (b) to treat deformities if they occur, (c) to teach activities of daily living and (d) to perfect the skill of the unaffected arm and retrain the affected arm to its maximum capacity.[1] This program, however, is meaningless to the toddler, so the therapist must find activities that give the child pleasure.

There is a place for passive manipulation in handling the preschool hemiplegia to prevent deformities but re-education depends mainly upon active motion for development of voluntary activity.[2] Concentrated passive therapy may produce a fairly relaxed arm but children who have received only this type of treatment regard their arm as a foreign object to be pushed around by the unaffected one. To avoid this the spastic muscles should be recorded but emphasis should be placed on using the nonspastic or mildly spastic muscles during the first few visits. This is accomplished through such gross bilateral activities as finger painting, soaping a mirror or table top, spreading talc on a smooth board or any similar activity needing no utensil. These activities incorporate horizontal abduction and adduction, the motions usually available to the little hemiplegia. At the same time the unaffected arm is trained in unilateral skills within the youngster's mental and emotional capabilities.[1] Thus one avoids isolating the spastic arm and hopes never to hear a mother say—as one once did—"Get in there and use your bum hand so the teacher believes you did your homework!" The aim is to interest the child in learning interesting activities for each hand. Toward this end, the tools of childhood are used—toys and play. Toys were furnished the clinic by members of the Toy Manufacturers of the U.S.A. in connection with the research studies of the American Toy Institute Research Division*. These studies are being carried out in co-operation with the National Society for Crippled Children and Adults. From the toys provided, a list most suitable to the needs of hemiplegic children was compiled (see charts). This form of training is highly popular with the children. The parents however who visualize therapy as a bitter pill to be swallowed for one's good are inclined to interpret planned play as aimless entertainment. One must educate these parents to realize that the ability to play is a learned skill profitably applied to the stages of growth and physical re-education. [3]

Through play, the unaffected arm is taught to lead and the affected arm is taken through the steps of simultaneous gross motion, relaxation while the arm works, assisting the lead, and finally reciprocal motion. With this program the affected hand is at no time competing with the total activity of the preferred hand and cerebral dominance does not become a problem. The first step in this program is to encourage gross movement from the shoulder.[1] For instance, both hands may "dance" to rhythmic music and this may be made even more attractive to the child by taping small plastic dolls, balloons or plastic airplanes to the dorsal surface of each hand. These rhythmics start with the movement easiest for the child then increase the arc of activity but always try to keep within the range of active assisted motion, if active motion cannot yet be attained. If necessary, move the arm passively. At the same time suggest that the mother find activities at home where the affected arm will ride along when placed on a toy (See chart A). This is also the time to introduce a soft beach ball, preferably shoulder width. With the child seated, make much ado by shouting "Are you ready?" and then help him spread his arms wide apart. The ball is never tossed until he is "ready" and an exercise is thus incorporated into play. In as much as the youngster may not clasp the ball quickly enough to prevent its bumping his face, choose a

†Supported by the New York State Association for Crippled Children.

*See "Play Therapy" by Eloise Parker, O.T.R., *American Journal of Occupational Therapy*, Vol VI, No. 2, page 194.

soft plastic beach ball or balloon with a small bell inside to weight it down.

A large ball is again an important tool at the next treatment step. The child is now encouraged to pick up the ball. Allow him to close his fist, for shoulder and elbow motions are the main objectives at this stage of treatment. Various games are used to encourage the movements desired, such as dropping the ball into a large box on the floor, into an armchair or down the exercise stairs. For older children who can take more resistance, throwing the basketball into an adjustable ring can be used to increase the arc of shoulder motion. Hand "dances" with batons or rolling pins may be done at this time. These not only lend resistance but encourage forward flexion of the shoulder rather than the abduction which occurs when hands operate independently (See chart B).

Elbow motions are next in the progression of activities. Dr. Deaver points out an interesting neuromuscular phenomenon: when the hands are clasped or even brought into contact, the elbow can be flexed without any abduction of the shoulder.[1] This can be incorporated into children's activities by using such bilateral toys as nested blocks or standing puzzles. Another good elbow activity, and a favorite with youngsters, is "baking." A household size rolling pin and cookie cutter are used. The toys of this type proved to be too small. When both hands are helped on the rolling pin, the "bakers" try hard to flatten the dough. As soon as a large cake is rolled, the lead hand is allowed free run with a cookie cutter. Another home-made and popular item is blowing bubbles which is performed by lifting a stick with both hands and blowing soap bubbles from a ring which has been suspended from the center of the stick. Singing action games such as "Pease Porridge Hot," "This Is the Way We Wash Our Clothes," "Looby Loo" and "Eensy Weensy Spider" may be modified to eliminate fine finger action and be used profitably at this stage of shoulder and elbow activity.

Up to this point gross bilateral motion has been encouraged to build up mental and physical association of the affected arm. Another problem now arises: that of teaching the affected arm to relax while the lead hand works. This can be accomplished by placing a padded spool in the spastic hand to break the tension pattern and to maintain the position of maximum efficiency [4], by using a strap on the table to restrain elbow flexion or by holding the forearm down with sandbags. Next the affected arm is given an unskilled job of its own to perform, such as holding down a large paper to be painted, folded or glued. Older children may hold down stencils, patterns or rulers while the lead hand completes the activity. If more resistance is desired, toys may be chosen which promote use of the arm as a holding assistant even prior to finger grasp (See chart C). This systematic development of shoulder-elbow independence in a spastic arm lays the foundation for reciprocal hand-foot pattern in walking and for spontaneous use of the affected arm in bilateral activity. At one time it was hoped that the general use of the spastic arm, combined with resistance applied as early as possible, might eliminate the difference in girth and length between the two arms. However it seems that a functional advantage results rather than an increased rate of physical development. This experience supports the opinion that "discrepancy in length of the two arms cannot be explained on the basis of disuse since it is often disproportionate to the amount of disuse; more likely, involvement of a 'developmental center' in the postcentral gyrus of the contralateral portion of the brain is responsible." [5]

Action at the wrist is so integrally tied up with that of the hand that there is no point in isolating it at the preschool age. It is best to incorporate wrist motions with hand activities. Two activities which amuse children and have a functional value are to grasp a number of small plastic dolls and drop them into a bowl of water and to place small rubber balls in each hand and drop them at the top of an inclined box. In the beginning all release of the spastic hand is done with the assistance of the therapist who either tips the wrist down to extend the fingers or forcibly extends the thumb, thereby bringing an unlocking reflex into play.[6] Active release of pegs, cymbals and jingle bells used in rhythmics often precedes active grasp. Here a word of caution must be given—do not pull the distal phalanx of the thumb around a toy, but place the spastic fingers around it, taking care to lift the thumb at its base. Too many subluxated thumb joints have been found in children where this was overlooked. Another general rule applicable at this time is to use the affected arm only when natural bilateral activities are present. Do not overtrain it or subdue the preferred hand by forcing unnatural bilateral activities. For example, little success has been noted in using finger painting to open a tight fist since the child invariably does fanciful unilateral designs forgetting the spastic hand. A basin of water, floating soap, plastic dishes and washrags will often be a better bilateral incentive. At mealtime, the child who can lift a glass with one hand strenuously resists a two-handled cup proferred by his overeager mother. Bilateral situations must be valid for the child to accept them.

When some active grasp and release is present in the spastic hand, bilateral activities are introduced wherein the assisting hand is used as a static holding aid. Simple activities such as zipping up

a garment or placing poker chips into slots in the sides of empty milk cartons which will tip over if not held by the assisting hand are interesting to the child and produce the desired motions. There are also a variety of toys which can be graded according to age as well as resistance (See chart D). When the child can grasp in pronation, he will need the therapist's assistance to grasp in supination. The therapist should grasp the forearm firmly and assist in supination, rather than trying to supinate the arm by turning the hand for this causes strain on the wrist joint which may jeopardize the efficiency of the hand.

Reciprocal bilateral activities are recommended for those children whose dominance has not been affected by the disability, who have firmly established a transfer of dominance [7] and are not currently disturbed by convulsions, emotional instability or speech difficulties. The therapist who can work in the tonic neck reflex [8] or synkinetic movements [9] will enhance the purpose of these activities. Reciprocal bilateral activities may be graded from rhythmics and hand singing games to toys calling for considerable resistance and facility of both hands (See chart E).

A short attention span is the greatest stumbling block to the treatment of the preschool hemiplegic child. A therapist is justified in making this her first consideration for there is more carry-over of therapy into daily activities if the child's attention span is within normal limits. It is essential to know the mental level at which the child is functioning in order to bring his physical capacity up to the possibilities of his mental age. In addition to the activities useful for the child's specific spastic disability, greater progress will be made if the therapist knows the activities which children perform at various age levels. [10] Whether he be retarded, normal or precocious, the preschool hemiplegia in each instance will be a happy little individual if met on his own level, given satisfying tasks within his capabilities and accepted for the worth of his accomplishments.

TOYS SELECTED FOR THE PRESCHOOL HEMIPLEGIC CHILD

CHART A

Toys Encouraging Passive Co-ordinated Motion of the Affected Arm

1. Mower Chime ....Gong Bell Mfg. Co.
2. Cowboy Chime Hobby Horse..Fischer Price Toys, Inc.
3. Carriage ....Hedstrom Union Co. & Playtime Products, Inc.
4. Huffy Convertible Bike............Huffman Mfg. Co.
   Junior Vehicle ....Junior Toy Corp.
   Tricycle No. 6514............................Garton Toy Co.

CHART B

Toys Encouraging Active Co-ordinated Motion of the Affected Arm

1. Balloons ....Barr Rubber Products Co.
2. Vinylite Ball ....Bilnor Products Corp.
3. Nested Blocks ....Sam'l Gabriel Sons & Co.
4. Loom (beater) ....Paul Bonhop, Inc.
5. Build-up Puzzles ....Sifo Co.
6. Traveling Top ....Porter Chemical Co.
7. Junior Ace Basketball Set.................................N. Y. Toy and Game Mfg. Co.

CHART C

Toys Encouraging Use of Affected Arms as Static Holding Assistant

1. These Fit Together ....Sam'l Gabriel Sons & Co.
2. Ring Toss ....Transogram Co., Inc.
3. Transportation Set, 2-pc. puzzle.......................Sifo Co.
4. Circus Set, 2-pc. puzzle.......................................Sifo Co.
5. Pump-a-Ball ....Playskool Mfg. Co.
6. Tot's Tool Box ....Paul Bonhop, Inc.
7. Accordion ....Magnus Harmonica Corp.

CHART D

Toys Encouraging Use of Affected Arms as an Active Holding Assistant

1. Playing Cards (sorting, dealing).........Ed-u-Cards, Inc.
2. ABC Sewing Cards ....Sam'l Gabriel Sons & Co.
3. Sew-on Cards ....Ed-u-Cards, Inc.
4. Loom (shuttle) ....Paul Bonhop, Inc.
5. Bonhop Beads, assorted shapes..........Paul Bonhop, Inc.
6. Jumbo Beads.....................................Playskool Mfg. Co.
7. Sewing Box ....Playskool Mfg. Co.
8. Twist-a-way ....Childhood Interests
9. Color Tree ....Childhood Interests
10. Sailor Boy Peg Boat..................Holgate Brothers Co.
11. Col-O-Rol Blocks ....Playskool Mfg. Co.
12. Rocket Launcher ......Toy Enterprises of America, Inc.
13. Train-Apart ....Strombeck-Becker Mfg. Co.

CHART E

Toys Encouraging Reciprocal Bilateral Activity

1. Stick'ems to Push Out ....Platt & Munk Co., Inc.
2. Two-Inch Plastic Dolls ....Renwal Mfg. Co., Inc.
3. Landscape Peg Set.......................Playskool Mfg. Co.
4. Q-T-Zoo ....Brian Specialties, Inc.
5. Old Woman of the Lacing Shoe..Holgate Brothers Co.
6. Junior Erector ....A. C. Gilbert Co.
7. Bill Ding Clowns ....Strombeck-Becker Mfg. Co.
8. TinkerToy ....Toy Tinkers Inc.
9. Bolt-It ....Toycraft Corp.
10. Snap Blocks ....International Molded Plastics, Inc.
11. Molly Kewls ....Paul Bonhop, Inc.
12. Ring Whizz ....Sam'l Gabriel Sons & Co.
13. Train, Tracks & Blocks....Skaneateles Handicrafters, Inc.

BIBLIOGRAPHY

(1) Deaver, George, M.D.: "Rehabilitation of the Hemiplegia," *Rhode Island Medical Journal*, August, 1951.

(2) Carroll, Jeanne, O.T.R.: "Utilization of Reinforcement Techniques in Program for the Hemiplegic," *American Journal of Occupational Therapy*, Vol. IV, No. 5, Sept.-Oct. 1950.

(3) Menninger, William C., M.D.: "Recreation and Mental Health," *Recreation*, November, 1948.

(4) Bunnell, Sterling, M.D.: "Occupational Therapy of Hands," *American Journal of Occupational Therapy*, Vol. 14, No. 4, July-August, 1950.

(5) Perlstein, M. A., M.D.: "Infantile Cerebral Palsy," *Journal of American Medical Association*, Vol. 149, No. 1, May 3, 1952.

(*Continued on page* 235)

GROUP THERAPY WITH THE CHRONICALLY ILL

BENJAMIN KOVEN, M.D.
Director of Physical Medicine
Rehabilitation Department*
FRANCES L. SHUFF, O.T.R.
Director of Occupational Therapy*

In treating the chronically ill, many problems face the therapist. Chronic disease entities such as multiple sclerosis, arthritis, hemiplegia, spina bifida and cerebral palsy often handicap the patient to a point where there is little he can do physically. Vast differences in age may preclude an overall therapy program and suggest to the therapist that only individual treatment can be effected.

During three years of intensive work in this area with all ages, it has been found that group therapy has most successfully met the needs of the chronic patient therapeutically and socially, and has aided him in adjusting to difficult hospital situations.

With long term institutional living whether in a custodial home or in a hospital, the chronically ill patient creates and lives in an egocentric world. He is assisted by nurses, attendants and volunteers as his daily needs require, and medical and therapeutic treatments are geared to help him overcome his handicap if possible. He is asked for nothing in return and easily grows accustomed to receiving with little thought for giving, nor is he concerned with the needs of others unless they in some way affect him. This is not entirely the fault of the patient but is caused by the psychological trauma associated with the handicap resulting from his disease, whether congenital or acquired. The limitations of the patient's social life caused by long institutional confinement is another factor that cannot be overlooked. Because of the large numbers of long-stay cases in hospitals for chronic illnesses and the nature of their mental attitudes, a means of helping them to adjust to an abnormal environment had to be devised.

Appreciating that the individual therapeutic approach with the aid of the medical, neurological and orthopedic staffs would be ideal, these cases were evaluated with this end in mind. However because of the lack of personnel and time, it was found impossible to meet the great individual needs, yet it was vital that the positive demands of these patients be satisfied in order that a healthy adjustment be achieved.

This was a challenge to the occupational therapy department that precipitated the organization of a large and varied group therapy program which succeeded where individual therapy was not possible or failed.

Group therapy is the participation in guided activity within and by a group to promote co-operation and social awareness and to give to the individual a sense of gratification through the achievement of the group. This must not be confused with club work, though clubs may be part of the program. A club is usually formed with one interest in mind (stamp collecting, gardening, literary activity, music appreciation), and though it may stimulate the individual it need not be directed toward group achievement. In group therapy the individual is respected but is always aware of what he, as an individual, can contribute to the group, rather than what the group will contribute to him. His satisfaction comes from group experience and his belonging to it. Its achievement gratifies him.

In the Jewish Sanitarium and Hospital for Chronic Diseases group therapy was first started with the children and then grew to encompass the adults. Both groups posed problems that could not be met by the occupational therapist alone, and so the aid of other departments was enlisted. The co-operation of the nursing, volunteer and speech departments was vital to the development of this program.

Most of our children have spent their entire lives in hospitals, some because it has been impossible to provide home care, and others because their families have not been able to accept them. One or two for social reasons have become permanent charges of the hospital. Their disabilities are typical, including problems of ambulation, co-ordination and speech.

Through our daily contact with these young patients we realized how little normal experience they had had. Familiar stories such as Little Red Riding Hood, Jack and the Beanstalk and Cinderella, were unknown. Common everyday objects were not perceived and when asked, the therapist was told that "potatoes grew mashed," horses "gave milk" and bread "came on a plate." Animals other than cats and dogs were strange and all group experience other than living on the ward was limited. Many of the children had never been inside a home with a kitchen, and family life was an unfamiliar phenomenon.

---

*Jewish Sanitarium and Hospital for Chronic Diseases, Brooklyn, N. Y.

A rhythm band under the supervision of a volunteer had been organized before this occupational therapy department was established, and working from that as a point of departure a dancing class was formed to which all children regardless of disability were invited. The purpose of this class was to stimulate the child's imagination, promote coordination and to provide generally an enriched experience. Stories were read and discussed on the ward by the speech therapist and these were subsequently dramatized to music in the dance class. Little episodes such as "going to the beach," dancing like a "rag doll," or doing a "tree dance" formed part of the program. It must be kept in mind that none of these children is ambulatory and all dance movement is performed in wheel chairs and with the upper half of the body. When the children grew tired they sang rounds which were enjoyed enormously, and these of necessity required complete group discipline. Our latest achievement has been folk dancing and square dancing. For those small patients who cannot take an active part in the program such as the severely handicapped cerebral palsied children, or those who are too young, an audience role has been created, and to this group the active participants defer.

This program has given most of the children a supervised dance-play experience. The retiring child can take his place within the group with little damage to his ego, whereas the more aggressive child can be given positive roles such as the witch in *Hansel and Gretel* to help rid him of his hostilities.

At a staff meeting when activities of our department were being revitalized, it was decided to accelerate our art program. One of the staff who had been working with the individual child in this field again found that there was a startling paucity of creative imagination, but that in a group one child stimulated the other. This was more sharply observed when a new admission joined the group.

Friday afternoon is now known as "painting day." Easels are set up and each child has his station. Some have worked in other media than paint, usually upon their own suggestion, and new projects are inaugurated on demand. The children have made a complete set of hand puppets and have built a stage on which a play that they have planned will be performed. Little allowance is made for their disabilities other than to adapt equipment to fit their needs and the success and gratification resulting from their efforts has given rise to a healthy enthusiasm.

To add to this integrated group experience a carefully supervised moving picture program has been organized. The children have a weekly movie hour, shown on the ward, which is built around a normal social experience. At first, thinking that a completely educational program would become dull we "sugared" it with cartoons, musical films, novelties and comedies, but we have noticed a growing preference for the straight documentary, although Mickey Mouse still gets a number one rating. Thanks must once again go to our speech department, through whose cooperation the program takes on fuller meaning with a related discussion and story hour that adds to their general knowledge.

There is always present in a hospital a group which has little interest in crafts and that resents specific direction. For this group participation in newspaper activity is invaluable. Space prevents us from going into a detailed account of how our newspaper has developed but suffice it to say that it has become an important factor in our institution and is the voice of the patients. It has served to encourage respect for another's opinion and has consolidated group thinking. So successful has this project become that material for future issues is always on hand. The staff meets together to discuss all articles submitted for publication and everything from editing to assembling is done by the newspaper group. Each member of the editorial staff takes pride in the paper as a whole and the patients consider this an intrinsic part of their hospital lives.

Gardening has also been a popular activity with a large patient group. Garden plots have been divided among patients who have requested them and garden instruction for soil cultivation and conservation has helped produce the harvest that boosted morale when adverse weather conditions proved most discouraging. For the severely handicapped patient who finds active gardening impossible, a garden club has been formed that meets once a month. Lecturers on flower arrangement, horticulture and ornithology have given interesting programs along with travelogues which have broadened the horizons of the hospital bound patients. Flowers and small plants are given to members who hold the lucky numbers at our meetings and once a year we celebrate with a large birthday party.

To further familiarize the patient with the world about him we have taken selected groups on field trips to various points of interest. Living in New York City has given us a wide range for choice and we have made the most of this. The Brooklyn Museum has been very cooperative in planning programs for all our patients regardless of age, and the park department has facilitated trips to the zoo. Twenty children were taken to the circus in the spring and a large

(*Continued on page* 219)

EVALUATION OF CLINICAL PRACTICE PROGRAMS FOR OCCUPATIONAL THERAPY STUDENTS

An Interim Report

CLARE S. SPACKMAN, M.S., O.T.R., Chairman
Associate Professor of Occupational Therapy
University of Pennsylvania, School of Auxiliary Medical Services
Philadelphia School of Occupational Therapy

HISTORY OF COMMITTEE

In 1948 the subcommittee on clinical training of the education committee of the American Occupational Therapy Association appointed a committee on the evaluation of clinical practice centers. As is customary, this committee was an area working committee, all the members[1] being located in or near Philadelphia. The committee has worked in close co-operation with the parent committee and the education office as well as having the services, when needed, of the consulting educational psychologist of the American Occupational Therapy Association. The progress of the committee has been slowed by lack of funds available to finance the project. Much of the mimeographing of materials has been carried out through the courtesy of the occupational therapy department of New Jersey State Hospital, Trenton. This has made the trial runs possible as the material was prepared. All of the tabulation of data to date has also been done on a volunteer basis by the committee. Special effort has been made and will continue to be made to secure financial support from a foundation for this project.

PURPOSE OF STUDY

The purpose of the study is two-fold:

(1) To develop a means of evaluating occupational therapy departments and the clinical practice programs which they offer.

(2) To ascertain what are the existing standards and practices of occupational therapy and clinical practice and what are the factors which differentiate a good clinical practice program from a poor one.

At the present time there are no known standards for occupational therapy departments or for clinical practice programs. Considerable work has been done however by the clinical training committee to standardize training procedures throughout the country. Some of the steps taken to improve clinical practice and promote uniformity are as follows:

(1) *A Directors' Guide for a Clinical Training Program for Occupational Therapy Students*[2] was published in January, 1948, and revised and republished April, 1950.

(2) A *Manual for Occupational Therapy Students in Clinical Training*[2] was published in 1950. This is used by all the schools of occupational therapy.

(3) A clinical training rating form for grading all occupational therapy students was prepared. Further study is being made of this for revision in 1954.

(4) Policies were formulated for the establishment of training centers, the ratio of students to therapists, the method of scheduling students, the dates for reporting for training and other similar procedures.

METHOD OF PROCEDURE

The first step taken by the committee was to study methods of evaluation used by other allied medical groups, such as the form used by the American Dietetic Association, the methods used by the American College of Surgeons for approving hospitals for residences and the procedures in nurses training. The American Physical Therapy Association had no formal procedure. The methods of evaluation used by educational groups were also reviewed, particularly *The Co-Operative Study of Secondary School Standards.* A conference was held with Dr. E. D. Grizzell, of the University of Pennsylvania, who was a member of the administrative committee.

The first step taken was to formulate the general overall plan of procedure, recognizing that changes would have to be made, depending on developments and possible financial support available. This plan was as follows:

(1) To develop a form which would give adequate data concerning the institution, the occupational therapy department and its clinical practice program in order to permit an evaluation of the program.

---

1. Naida Ackley, O.T.R.,; Ethel E. Huebner, O.T.R.; Alice Letchworth, O.T.R.

2. Obtainable from the American Occupational Therapy Association, 33 West 42nd Street, New York 36, New York.

(2) To develop a form on which each school using the institution for clinical practice for its students would evaluate the program.

(3) To develop a form on which students training in the occupational therapy department would report to their school on the training received.

(4) From the data obtained from these forms to establish the existing standards and practices in occupational therapy.

(5) To make available these standards for the use of other departments so that it would be possible for a department, given the forms and the standards, to evaluate its own program.

(6) To prepare material for the instruction of a visiting committee that would visit a department following the completion of the evaluation forms. This committee would check the paper evaluation of the department.

The second step taken was to prepare the form for the evaluation of the occupational therapy department. It was considered advisable to develop a form which would do this as well as evaluate (with a supplementary part) the clinical practice program. This form was presented to the clinical training committee for suggestions at the annual meeting in 1949. Fifty occupational therapy departments were then asked if they would complete the form. These were selected to represent hospitals of different types, sizes and financial support, as well as type of patient served and geographic distribution. Forty-five of the originally selected "guinea pig" hospitals co-operated. The data gathered from this first run was used only to determine whether the questions asked or information requested could be answered, whether it contributed to the evaluation and whether it was so phrased as to elicit the desired answer. The results of this study were reported to the committee at the annual meeting in 1950.

The third step was to rework this form from the above data and to develop a tentative score sheet for the evaluation of a department. The fourth step was to develop a form for the evaluation of the clinical practice program. This was prepared and sent out on a trial run to twenty-five clinical practice centers, representing the five major fields of occupational therapy with appropriate geographic distribution. All forms were returned. This data was again used to determine whether the questions were answerable. A revised form was then prepared.

The fifth step was the preparation of the form to be used by occupational therapy schools for the evaluation of a center. This will be sent out to each school regularly using a center when the center is evaluated. This form was presented to the sub-committee on schools and curriculum at its annual meeting in 1952. Their suggestions and comments were used in revising the form.

A form for the students to report on clinical practice has also been prepared and will be presented to the committee on clinical training at the annual meeting in 1953.

The completed form for the evaluation of clinical practice centers, which consists of three parts, is being sent out about September 1, 1953, to 75 of the 230 clinical practice centers. These have been selected to give geographic distribution and are divided among the different areas as follows: psychiatric, 25; general hospitals (including Army, Veterans Administration and United States Public Health Service), 20; physical disabilities and rehabilitation, 10; tuberculosis, 10; children's hospitals, 10. It should be noted that the large general hospitals usually offer training in several areas. A number of the centers selected train students from more than one school of occupational therapy.

The data from these forms will be used to determine the existing standards and practices. If for any reason the number of departments selected is not sufficient, others will be called upon to co-operate in this undertaking.

The present form being sent to the centers consists of three parts.

Part I pertains to the institution and personnel policies of the occupational therapy department. This section is to be completed by the superintendent or director of the institution.

Part II pertains to the occupational therapy department. This section is to be completed by the occupational therapist in charge of the department and the occupational therapy staff.

Part III pertains to the clinical practice program for occupational therapy students. This section is to be completed by the occupational therapist who supervises clinical practice and the occupational therapy staff.

The work of the committee has been greatly eased by the splendid co-operation from those working in the field.

FUTURE STEPS

On the return of the evaluation forms the data will be studied and it is hoped that a report can be presented by the spring meeting in 1954. Depending upon the results of this part of the study and the financial status of the association further steps will be determined. It is hoped however to extend the study to all clinical practice centers and, if possible, to supplement the paper evaluation by a visiting evaluating committee.

OCCUPATIONAL THERAPY IN THE TRAINING OF THE PRACTICAL NURSE

FRIEDA DROHOBICH, O.T.R.
Montefiore Hospital
New York, N. Y.

The value of balanced patient treatment is gaining greater recognition in the hospital situation. Since all the services in a hospital revolve about the care of the patient, this common interest should serve as a coordinator and integrator of the various therapies. In order to achieve optimum results close collaboration among the various departments must be effected. This can best be achieved through an educational program whereby other services are familiarized with the functioning of your department since understanding, appreciation and mutual respect are the foundations for a well-rounded and well integrated program of patient care.

At Montefiore Hospital which has a very active training school for practical nurses, this was seized upon as an opportunity to demonstrate the effectiveness of such an educational program. The practical nurse like the registered nurse, because of the intimate nature of her contact with the patient, is in need of indoctrination on the purposes and values of occupational therapy; even more so, since her role in the hospital is so recent and continues to grow.

A planned program for orientation of student practical nurses was initiated at this institution. It is now included in the curriculum of their training course and is a state requirement for all practical nurses. The course is given every three months for a group of 20-30 students and consists of five weekly sessions of two hours each. The material presented to the students is prepared by the staff therapists, each having one session with the group. As a result of this, the practical nurse becomes acquainted with the entire occupational therapy staff instead of a single therapist, thus further promoting interpersonal relationships and cooperation.

Included in this paper is a brief outline of the course of instruction for the student practical nurses at Montefiore Hospital. If a complete syllabus is desired, it may be had on request.

COURSE CONTENT

I. Lecture and Tour

A two hour lecture including a tour of the occupational therapy shops is prepared by the therapist to familiarize the practical nurse with the services and purposes of occupational therapy. The content of the lecture material and the practicum is designed to meet the needs of the group.

A. Objectives of the course

1. Give understanding of the basic principles underlying this treatment
2. Arouse interest in occupational therapy
3. Present practical nurse with some experience in occupational therapy to enable practical nurse to help patients in hospital or at home
4. Instruct in techniques of some of the minor crafts

B. Role of occupational therapist in the hospital

1. Person trained to keep patient mentally alert and happy and physically active within limitation of illness
2. Help patient adjust to illness and hospital environment

C. Definition: It is any mental or physical activity prescribed by a doctor and carried out by a trained therapist to help in his recovery from disease or injury and to aid in his adjustment to hospital.

D. Media (Methods): The media of occupational therapy may be educational and recreational activities, creative or manual skills. The type of activity selected by the therapist is dependent on the disability of the patient, the age and sex of the patient, as well as the interests and skills of the individual. The range of activities employable by the therapist is limitless. In planning a patient program the therapist might include woodworking, ceramics, weaving, leather, self-help activities, games, etc. Whatever activity is selected by the therapist is adapted to meet the needs, both physical and mental, of the patient.

E. Fields of service: Occupational therapy is used in the treatment of various disabilities. Among them are included: neurological, psychiatric, tuberculosis, cancer, blind and orthopedic cases. The importance of this type of therapy is extremely valuable for the hospitalized child also since it represents continuation of play activities and development of new interests and hobbies. (In dealing with this phase of the lecture visual aids are employed wherever possible to define more clearly how occupational therapy functions with a particular disability.)

F. Tour of occupational therapy shops

1. Value
   a. Treatment of patients is carried on in shops equipped for special activities, or on the ward if patient is bed-ridden.
   b. Shop offers a casual and informal atmosphere to the patient
   c. Shop promotes group activity, socialization and patient co-operation.
   d. Often acts as an incentive for patients—they are stimulated by shop activity.
   e. Patients enjoy being away from the wards where they are constantly reminded of illness.
2. Patient demonstration
   By observing the patients during treat-

(*Continued on page* 235)

Apparatus Aids

OCCUPATIONAL THERAPY AND THE HAND SPLINT

FRANCES SILVERSTEIN, O.T.R.

"Splints should be standardized as much as possible . . . They should be cheap and light, but still not offensive to the eye, easy to make and of simple construction, instead of elaborate with too much machinery. Splints should be easily adjustable, and not too bulky."[1]

The need for such hand splints as described above by Dr. Sterling Bunnell was felt in the occupational therapy department at The Hospital for Special Surgery soon after one of its therapists was invited to attend the hand clinic headed by Dr. Ramsay Straub and Dr. John Dorsey at its inauguration some three years ago. As the variety of patients increased, many were found who might benefit from active or "dynamic" splinting which could be made quickly and at small cost, which was light but durable, able to be adjusted to the patient's improvement, and which could be used to supplement prescribed occupational and physical therapy.

Several of the hand splints designed by Dr. Bunnell and described in the American Journal of Occupational Therapy[2] were modified to meet the clinic's special requirements using materials on hand or obtainable from the brace shop. The modifications developed in the occupational therapy department were based on the following of Dr. Bunnell's splints: the knuckle bender, the reverse knuckle bender, the finger flexion splint, the finger extension splint and the suspension splint for radial palsy. It became possible with available construction techniques to adapt these splints to fit hands of unusual sizes or peculiar deformities, although on no occasion did the occupational therapy department interfere with any work being done by the hospital's brace-making unit. It became possible to supply these new splints quickly and at a much lower cost than previously, and familiarity with the mechanics of the devices allowed alteration of the splints as the patient's condition improved.

However in some cases these initial versions of the Bunnell splints came into contact with the hand over fresh scars, were overly complicated or even insufficient, and it became necessary to further explore the splint-making field in order to provide the same basic movements and pressures, singly or in combination, as those used by Dr. Bunnell. The material which follows is a review of a portion of the research which ensued.

Active hand splints may be used to correct deformities by mobilizing joints, providing active and/or passive motion or by giving support in opposition to gravity. They may substitute for, or assist, defective muscles, or they may afford general limitation of motion. Splints may be used for any combination of the above. The use of active splinting, when indicated, assures that the joints will be kept mobile for a good splint should encourage the use of the hand after it has balanced the muscles in a position of function.

According to Dr. Bunnell, "Without splinting, the muscles become too long and the deformity from muscle imbalance eventually becomes fixed. Then after the nerve recovers and reinnervates the muscle, it has the additional task of shortening the muscle against deformity and against the pull of a strong antagonist."[3]

In all splinting, one of the most important factors to be considered is that of mobility. From a mobile splint the patient gains exercise in a guided functional position which ensures continued muscle tone, lack of adhesions and tightness. Atrophy and edema result from immobility with subsequent shortening of ligaments. Straps or cuffs which are too tight are another cause of edema and stiffness. It is equally important to check for signs of decreased circulation or undue strain.

Splints should be designed to offer little or no restriction to the uninjured parts of the hand. Splints which contact the palm of the hand should maintain or reinforce the normal metacarpal arch and — unless stabilizing the metacarpals in extension — should allow them to flex to their full 90° range. Palmar supports should be of minimal size so that they do not interfere with the natural function of the hand.

In a hinged or moveable splint, the pivotal portions should coincide with the center of movement of the joint, and the splint should move easily through the complete range of motion before it is placed on the patient.

The hand splints described below can readily be made by an occupational therapist in a department with little or no unusual equipment. Splints illustrated have been made of the following materials: plexiglass, plaster-of-paris bandage, wire, leather, felt and rubber bands. Equipment consisted of a table vise, heavy pliers and wire

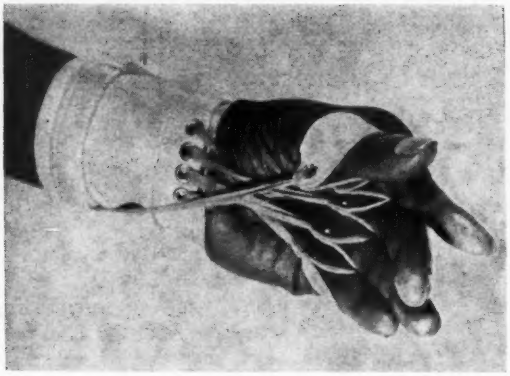


Figure 1

cutters, a coping saw or an electric jigsaw and, infrequently used, a hot plate for bending plastics.

It has been the practice of the author to plan the splint on the hand itself after obtaining the prescription and discussing the proposed device with the physician while the therapist is present in the clinic. The device is elaborated on paper during the first visit, the component parts are built between visits, and these are assembled, corrected and recorrected if necessary, on the next. During the patient's course of occupational therapy, changes in his condition are readily noted for report to the physician when the patient is next examined in the clinic.

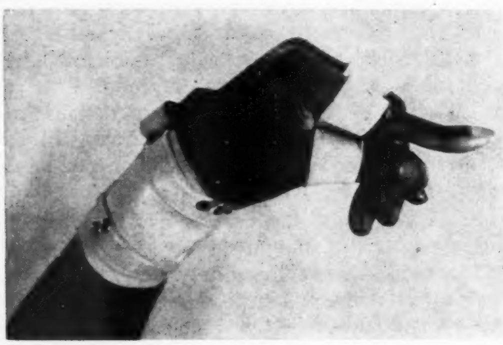


Figure 2

One of the simpler splints devised was for the purpose of obtaining metacarpal flexion. As you can see by the photographs (Figs. 1, 2) the splint consists of a leather cuff which is buckled around the arm at the wrist. Small cuffs, also of leather, pull the fingers down across the palm, fastening to the wrist cuff with rubber bands which can be adjusted to increase the amount of pull desired. Cuffs in Figures 1 and 4 slant across the palm in order to cup the fingers as in normal movement. In Figure 2 the cuff at the thumb crosses over the palm in order to bring the thumb down into opposition. This cuff is feathered on the inside edge to allow it to slip down over the metacarpal-phalangeal joint of the thumb to ensure the proper oppositional pull.

All points where eyelets may irritate the skin are protected by additional pieces of leather on the inside of the cuff, using a firm, natural-colored sheepskin. Straps are glued to the cuff, then machine-sewn with a large stitch and heavy cotton or linen thread.

This splint was used by the patient for the dual purposes of stretching to correct the deformity at the metacarpal joints as well as for an exercise device. Occupational therapy, administered twice weekly, as a follow-up on the use of the prescribed splint emphasized metacarpal flexion and inter-

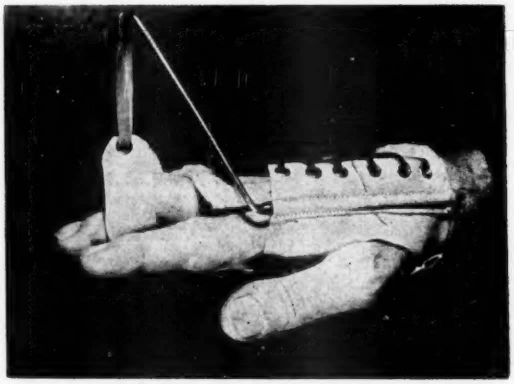


Figure 3

phalangeal extension through such activities as guided manipulation of Theraplast, a looper potholder project adjusted so that the stretching of the loopers themselves offered resistance and work with built-to-fit corrective sandblocks. Although it was not used during occupational therapy, the patient performed many household activities at home while wearing the corrective splint in an effort to mobilize the hand by taking advantage of constant function.

"Occupational therapy achieves real success in reconstructing crippled hands. It should commence as soon as consistent with the healing of the wounds, and be continued until the time of reemployment. It is important to treat the patient as a whole as well as the injured part to keep the patient both physically and mentally a worker instead of an invalid. The activity selected should be of interest to the patient who should then be spurred on by competition and the joy of accomplishment with a creative objective and interest."[1]

A more complex splint is pictured in two different versions in Figures 3 and 4. Both patients are arthritic; the splints were prescribed for extension at the interphalangeal joints and, as in all instances, were checked for the final fit with the physician in charge. The splint consists of a soft, fingerless, closely-fitted leather hand cuff in glove

form, laced down the back. Copper-covered Bessemer steel wire (obtained from the brace shop) is slipped into tube-like carriers sewn to the glove and the finger cuffs are attached to it. In order to control the pull so that it does not occur at the metacarpal joints, a piece of plexiglass covered with a protective piece of felt is placed over the back of the hand, inside the glove, so that it extends almost to the interphalangeal joints. Because it is made of this plastic, this piece may be heated and curved to fit the metacarpal joint where it is necessary to ensure adequate stabilization at this point.

It may be noticed that on each of these two splints the wire is bent at a different angle. This angle is an individual one depending upon the

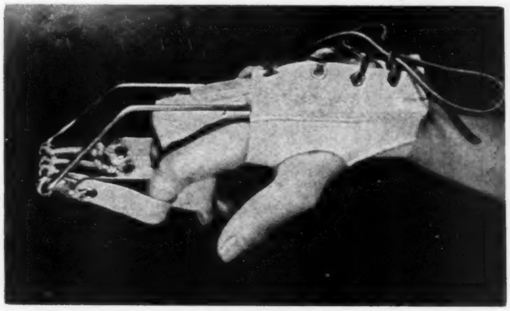


Figure 4

amount of flexion present at the metacarpal joint and arrived at by estimating the approximate line of movement of the fingers from the flexed to the extended position. This principle of splinting functions most efficiently when the angle of pull of the elastics is at right angles to the finger segment in question.

Because of the extreme irritability of arthritic joints, these splints were worn for increasing periods of time as the patients judged best and no special emphasis was placed on activity of the hands while the devices were worn. An extended course of occupational therapy was possible in only one case where it was administered without the splint. In this instance, the splint was developed to reinforce the functionality of position at which exercises were aimed. Home exercises were performed by both patients and were a continuation of supervised exercises adapted to home equipment and household activities.

Many of the splints made in the department work on the principle of wire "outriggers" which slide into place on a glove or cuff (Fig. 3, 4) including the common banjo splint. This technique is especially useful when the patient is wearing an arm cast and wishes to temporarily remove the splint wire (for instance, in order to dress or undress) which he could not do if it were plastered

Figure 5

directly into the arm cast. These outrigger cuffs can be used in combination with any other supportive device as well (Fig. 7).

In order to achieve a greater pull on the joints involved, the angle of wire may be changed or the rubber bands may be shortened, remembering to maintain the 90° angle of pull on the fingers throughout the entire procedure. Rubber bands are preferred to springs because they are cheaper, more convenient to replace, and the inevitable loss of tension due to wear can be more quickly noted than in a wire spring.

Another splint devised and in use at this hospital is the opponens splint pictured in Figure 6. Made of elastic webbing and leather, it is light,

Figure 6

washable and extremely effective. Figure 5 illustrates the poor metacarpal position of the thumb without the splint.

There are other opponens splints currently in use, originated in other occupational therapy departments, which may be of more value if complications are present since the splint illustrated requires a normal wrist with an absence of irritable

Figure 7

scar tissue on the palmar surface where the webbing contacts the skin.

With these splints pictured, all movements of the hand and thumb are encouraged because increased use of the hand in the splint-held functional position is felt to be of great value as an aid in strengthening the entire hand musculature. The opponens splint was worn by a wheelchair polio patient who found it of considerable value. For instance he was able to manipulate the wheelchair in a normal manner rather than with the base of the palm as before—certainly a most practical application of occupational therapy. The splint has been used on a few arthritic patients as well.

The complex methods of making various stable wrist and palm supports such as the cockup splint with such materials as plexiglass, celastex, and fibreglass have been partially abandoned at The Hospital for Special Surgery in place of plaster-of-paris bandage which is light, relatively durable, easily molded to fit the arm firmly and even cleanable if it is given several coats of shellac when completely dry. This has been found to be especially helpful for short-term cases.

Figure 7 shows such a splint with a plastered-in wire outrigger. The finger cuffs, attached by elastics to a leather wrist cuff, ride over the outrigger to maintain the proper angle of pull. The plaster cast is lined on the inside with cotton stockinette. This patient is arthritic and the splint was prescribed for metacarpal-phalangeal flexion and wrist cockup.

The patient was seen while in acute pain, the splint being worn for gradually increasing periods of time. Since the patient was recovering from corrective surgery, the occupational therapy prescription was for corrective splint and encouragement of general hand and arm motion only.

In many cases it is necessary to follow the patient's progress with new splints as the hand improves beyond any possible adjustments of elastics or wires on the splint then being worn. Figure 8 shows part of the progress, splintwise, of such a case. First a banjo splint was prescribed to hold the fingers in abduction and extension following skin grafting for burn scars on the palm of the hand and fingers.

As the next step, the same patient was given a metacarpal-phalangeal knuckle bender similar to that in Figures 1 and 2. The third step (Fig. 8) shows the patient wearing the elastic knuckle bender with an outrigger attached to give extension of the interphalangeal joints. The elastics counter-balance each other and the splint was worn for exercise as well as positional purposes.

With this patient in particular, as with most of the splinted cases, a carefully supervised occu-

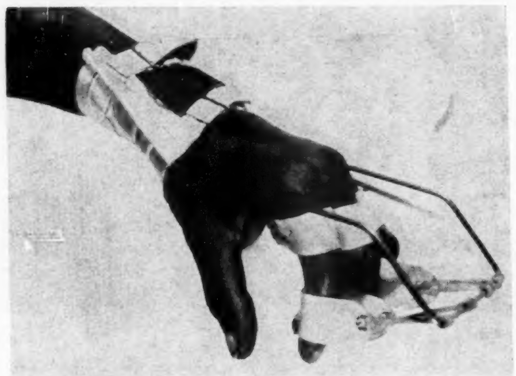


Figure 8

pational therapy program was planned. In this case occupational therapy consisted of gradually increased resistive exercises with sandblocks and a floor loom project using a beater adapted through the addition of shaped blocks to reinforce the corrected position of the hand.

Many of the operative hand cases also receive physical therapy in the form of heat and massage and active and assistive exercises immediately prior to occupational therapy and coincidental with it for this is believed to be the most beneficial arrangement.

All phases of occupational therapy are administered with the aid of regular medical supervision in the hand clinic where changes in exercises and splinting are ordered.

SUMMARY

The foregoing paper has attempted to indicate some of the principles and procedures employed in the occupational therapy department of The Hospital for Special Surgery for the development and production of hand splints of various types, based on those used by Dr. Sterling Bunnell and

(*Continued on page* 222)

SOME USES OF THE SUSPENSION SLING IN THE TREATMENT OF POLIOMYELITIS*

VIOLA W. SVENSSON, O.T.R.
MIRIAM C. BRENNAN, O.T.R.

Parts for Bed Sling

First try at feeding with aid, using modelling wheel for plate rotation. Notice position of balancing bar for better use of slings for this patient.

Low raised bed creates other techniques to solve problem of managing food from plate to mouth.

Early Stages: Bed slings are used after muscle pain has subsided to develop ability in self-feeding for the severely involved polio patient. The patient eats better if he is not fed by someone else, and feels less dependent generally. Rather than allow poor positioning and unlimited substitution in a haphazard fashion devised by himself, a sling is attached to the patient's bed, is properly fitted, and he is taught how to use it by a therapist. He can also use the sling for grooming.

Early functional shoulder work can be started with the bed sling on the ward working for range of motion with graded activities. Adductor tightness can also be stretched by positioning the shoulder in some abduction and increasing the range gradually.

These slings are equipped with springs to avoid the hazards of weights in small ward areas.

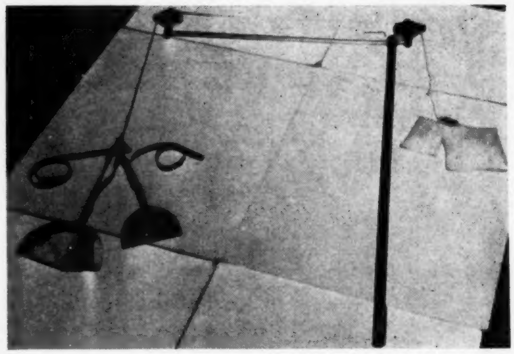
Convalescent Stage: When the patient can come to the shop in a wheelchair, the floor or table slings with pulleys and weights are used.

To determine the amount of counterbalance, the patient is put in the sling with trial weights, asked to abduct the shoulder to 90°, protract and retract, then return to the adducted position. This is done ten times and the least amount of weight necessary is determined. The amount of weight needed varies with the size of the patient and the amount of the muscle power in the shoulder. In a flail shoulder, the arm is counterbalanced to the desired position where the arm may be used as an assistant if the other arm has normal function.

As an exercise device, the sling can be used for active assistive motion. The number of pounds of assistance required is measurable and can be checked to show whether or not the muscle power is increasing. A craft can be chosen to fulfill the desired motions that will provide the needed exercise.

*Fourth of a series of illustrations of apparatus aids toward independent activities as designed and constructed in the occupational therapy department of the New York State Rehabilitation Hospital, West Haverstraw, N. Y.

High raised bed makes feeding problem easier to solve. Bilateral slings used here.



Parts for Floor or Table Slings

Slings made for wooden wheelchair can also be put on ordinary wooden straight back chair.

Chair slings attached for feeding. Utilized also for daily activities such as grooming, brushing teeth, washing etc.

Table Type Sling

Precautions to be Observed: The strength of the shoulder girdle should be known so that weak adductors will not be stretched or a tight upper trapezius encouraged to remain tight by allowing too much upward rotation. It is sometimes better to use bilateral slings in a growing child, even if one shoulder has normal function, to prevent poor posture which might encourage a scoliosis.

Chronic: For the permanently disabled patient who has some shoulder muscle power, wheelchair slings will enable him to perform his daily activities better by mobilizing the shoulder joint.

A woman in a wheelchair usually finds it easier to do her cooking and cleaning with the aid of a sling, as long as she works within a small area.

By the use of slings, the muscle power present can maintain its level of power. Without slings below functional muscles cannot operate against gravity and therefore may atrophy from disuse. Therefore with the slings, functional uses include the ability to groom, to feed oneself, to type, etc. These activities might be impossible otherwise.

GROUP THERAPY

(*Continued from page* 209)

number of adults visited the rose garden of the Botanical Gardens. These are a few of the experiences we have been able to afford our patients in group activity.

These trips are not simple to plan and become a major project in execution. Besides clearing with hospital departments such as the administration, nursing and the medical divisions, outside agencies must be contacted, cars engaged for transportation, a truck reserved for wheelchairs and an orderly, nurse and volunteers assigned in attendance for any patient who cannot manage a wheelchair. If steps are to be mounted at the point of destination a ramp must be brought to facilitate entering a building. We have been able to introduce this program successfully because of the encouragement and cooperation we have enjoyed from all departments as well as the administration within the hospital.

Recently Scouting projects have been inaugurated and, although this is being directed by regular leaders, therapeutic guidance is offered by the occupational therapy department. A small barbecue is being built on hospital grounds, and a tent which will house six cots erected near by. This will give the children a camping experience without encountering the hazards of terrain that is rocky or too difficult for wheel chairs.

Group therapy planning has also been introduced into our craft work where some patients have been divided into small working teams. This has been experimental with the idea of building up to assembly line work. No one of the individual patients on these teams can complete an entire project by himself, and the dependence on each other and cooperation within the team has made for a healthy working situation which is preparing them for future sheltered employment.

At present plans are being made to make this possible within the hospital organization, and with its advent the cycle of rehabilitation toward which our efforts have been directed will be completed. Patients for whom the future held little promise will have greater reason to strive to overcome their enormous handicaps and to take their place in a dynamic world.

NATIONALLY SPEAKING

From the President

One year as your president leaves me with reflections I would like to share with you.

This year has been interesting indeed. The office affords a vantage point from which to view the whole field of occupational therapy with an increased perspective. It is stimulating to see the forest in spite of the trees. Long-range view points are coming into focus. This has a direct bearing on education. The two are inseparable. The field is made up of school graduates who in turn become the clinical staff members. They define what is required of an occupational therapist and what constitutes the scope of his field. It is a splendid cycle which continually picks up medicine's analysis of our clinical performance and incorporates it into the education of oncoming students. The schools and clinical training centers simply implement these basic principles into a course of training for new graduates according to their respective educational pattern.

What is an occupational therapist? Let us reflect a moment without rushing into definition. He (we must no longer say she) is an out-going person whose interests are centered in other people. He has a keen awareness of his fellow man. He recognizes that in this demanding pattern of 20th century life the emotional and physical stress man meets is great. Man must prepare for and accept this stress to enable him to proceed toward his goal with whatever success might be his to enjoy. Hot or cold wars and economic instability add to family tensions. Mechanical denizens test the fragility of a man's body causing serious accidents. Physical and emotional trauma await him. The breakdowns are many; little ones and big ones. Medicine seeks to prevent, repair and control the effects of such trauma or insult (including disease and injury). The role of the occupational therapist is determined by the physician's use of this service; it is demanding, challenging and thoroughly gratifying.

The occupational therapist himself must be ready to play this role with skill and assurance. He must be of full emotional stature himself to carry the load. He must have a realistic understanding of the demands life has placed on those patients referred for his care; whether the diagnosis and prescription be essentially physical or emotional. He must have a working concept of how people react to each other for better or for worse. He must evaluate what people need under given circumstances and how these needs can be met within the confines of existing circumstances. He must be able to see himself and others in relation to community as well as world problems.

Most of us fall short of attaining such complete stature and have some tendency to limit our understanding to immediate problems. The occupational therapist needs skill in technical performance and theoretical knowledge to enable him to contribute to a therapeutic program. Above this, however, he needs an understanding of the personal reactions of the human creature to fully perform his work. This latter concept is a partly built-in commodity but education and experience contribute a great deal. May we keep this concept bright! May we never focus so minutely on the function of the part or the immediate behavior that we lose sight of the man as a whole and his relation to time and environment. There is some danger of this occurring as we polish our interest in special diagnostic groups of patients.

The factor that is particularly significant in occupational therapy's contribution to the treatment program is the *total individual in performance,* physically, emotionally, socially and intellectually in relation to his needs. This we keep telling ourselves. As occupational therapy puts faulty parts or reactions into performance for greater development it is the patient's relation to his own personal needs that drives him on to improved performance or stereotypes his effort. He must feel and know achievement at each level to continue the climb. Achievement of course might be physical or emotional; both are vastly important and must be ingrained in the treatment plan. This clearly defined sense of gradation and stimulation and its flexibility within the prescription is what singularizes the activity program of occupational therapy.

Combined into the concept of occupational therapy are basic principles shared with and often refined by other professional groups; psychologists, physical therapists, fine craftsmen, the teachers and others. Separately they do not constitute occupational therapy. Combined and applied to actual performance under medical prescription they become a vehicle by which a patient can acquire maximum development incorporating his own motive and will power. It is this combination of the patient himself plus materials and guidance in performance that make occupational therapy. The guidance is the planning, the encouraging, the tethering, the timing and the open control that the occupational therapist applies. It is dictated by fundamental principles of psychology and physiology brought to focus in the medical prescription.

All this is not new. What is new is the increased effort on the part of the occupational therapists to clarify and accentuate in his own mind

the objectives he pursues and the approach he employs so that he might more accurately evaluate his work. Careful evaluation of detail without loss of perspective is not easy. We need to keep our total philosophy in operation at the time we are scrutinizing detail for our most effective performance. We need to keep those things we call the intangibles, knowing that they exist because they are effective. We need, however, to make them more accessible and usable in a treatment program by transforming them into measurable ideas that can be weighed and evaluated along with other scientific material. Let us keep concept while accumulating data.

Henrietta McNary, O.T.R.
President

From the Executive Director

In this issue of the Journal, you will read the midyear report of the Speaker of the House of Delegates and minutes of the Board of Management. Some of this is information that you have already had through your delegate, but we are printing it in full in this issue for you to review and refresh before the 1953 conference at which further reports and action will be discussed. This is an appropriate time as it is one month prior to the conference which marks the period when we take a careful look at ourselves in an annual evaluation.

Have you been conscious of the progress and advances of your profession this year? Have you made some effort to remedy the things you have critized or recognized as weak points? As a member of your local OT association, are you ready to help your delegate by suggesting worthwhile items to be carried to the House of Delegates and Board for discussion?

Here are some of the matters which are included in the reports and are undergoing committee study. You should familiarize yourself with them if you have not already done so. A cross section of items such as these spell the trend and growth of our profession:

Chapter and/or district formation of state associations; recognition of non-registered personnel (OT assistants and aides) through proposed standards of training and accreditation; new classification of professional membership; re-establishment of an auxiliary registry; provision for officers-elect, in which the president and treasurer would be elected one year prior to taking office and would serve during the ensuing year as non-voting members of the Board and Executive Committee; provision for the nominating committee chairman to change from an office appointed by the president to election by the House of Delegates; clarification of the organizational pattern and role of the occupational therapist in the physical medicine and rehabilitation division of the Veterans Administration. Look at the committee studies of an educational nature which include a new definition of occupational therapy; shortened curricula; career inventory (student selection instrument); evaluation of OT departments; graduate study.

Marjorie Fish, O.T.R.
Executive Director

From the Educational Secretary

Over a period of years we have had a number of different report forms for evaluating students in occupational therapy. Several scoring procedures have been utilized as well as a variation in format and content. It is logical that such should be the case. In fact, had the opposite been true, it would be a cause for great concern. Progress and growth require a certain amount of flexibility and change.

The construction of such report forms is not the work of any one person. As is the case of the present experimental form, *Report of Performance in Clinical Affiliation,* it represents the efforts of a special committee. This group worked diligently to secure a complete coverage of pertinent material; duplications were deleted; phrases were rewritten for clarity; additions were substantiated. Also this particular report has had a "trial run."

It was originally built as part of the development of the Career Inventory. Many therapists who used it in this connection recommended it for regular student evaluation. At the midyear meeting in Kansas City it was voted to revise the report wherever necessary and use it experimentally from July, 1953, to July, 1954. Some changes were made in the report by a committee and the new form was mailed to all clinical training centers listed by the schools as training students this summer. The schools will assume the responsibility of supplying the report for the remaining months of the experimental year.

The present official form will continue in use while data is collected on the experimental form. Analyses will include the following: there will be a comparison of scores on the two forms for every student on each affiliation; the pattern of score distribution will be determined; the concentration of scores at any given point will be investigated; the effect, if any, from the order of affiliation will be studied; and a careful analysis of all points marked "not applicable" will be made to ascertain if they should be retained.

So much for the statistical analyses. From the

comments on and evaluation of the experimental form by the supervising therapists, we will be able to determine a number of other factors. In this relation semantics always enters the discussion; as before, the preference of the majority will be our guide. The recommendations to include or delete any traits will be reviewed carefully by the committee. Last but not least, we welcome any suggestions for improvement of the format. The increased number elements to be scored multiply the difficulties in this connection.

Now let us consider the content of the experimental report. Part I consists of fourteen traits which were regarded as integrally related to the practice of occupational therapy. They are not limited to the ideal student in a select situation but are applicable to any student in any occupational therapy department. These traits have been broken down into eighty-four elements. They include both negative and positive characteristics. In this manner the eleven points in the present clinical training report form have been covered and further developed.

Each trait has been carefully defined. By delimiting the points to be considered a form of standardization has been insured. The student will be rated on the same factors in every affiliation, that is, as far as such is humanly possible. The number of elements under each trait varies from four to seven as the situation demanded. This is in contrast to the present form in which they had been limited to three with a scale of three points within each component.

Part II is made up of six components which cut across and include the specific traits listed in Part I, thus they supplement each other. The notable difference is in the method of evaluating the student on the two sections. In Part I the points being considered are checked as they apply: most or nearly all of the time (75% or better), half of the time, rarely or never (25% or less) and "not applicable" when there had not been an opportunity to observe this specific deportment. Each element in this section pertains exclusively to the behavior of the student being considered, whereas, in Part II, the quality of the student's performance is evaluated in relation to that of other students in clinical training. Here the necessary check mark is made in the appropriate column indicating that on this component alone the student is being classified as superior or poor as the case may be in relation to students previously trained. In this division only, the normal distribution curve has been utilized (*Superior* 7%, *Above Average* 25%, *Average* 36%, *Below Average* 25%, *Poor* 7%).

For the period of experimentation the new reports will be scored in the education office. When the compiled data is reviewed at the completion of the study, the decision will be made as to the best place to incorporate the scoring for future use.

The co-operation and objective criticism of all — students, clinical director, and school director — is vital to the accomplishment of our goal. We are striving to develop a report form that accurately evaluates the performance of all students in the practical phase of our training program. What can you contribute to attaining this objective?

Martha E. Matthews, O.T.R.
Educational Secretary

HAND SPLINTS

(*Continued from page* 216)

modified to yield simplicity of production, use of common materials and ease of adaption to meet the specific needs of individual patients. Occupational therapy in each of these cases was discussed. Also stressed was the necessity for close cooperation between the physician, the occupational therapist and the physical therapist — exemplified by the hand clinic of this hospital — so that the patient may be assured the correction demanded by his particular disability.

REFERENCES

1. Bunnell, Sterling, M.D., *Surgery of the Hand*, J. B. Lippincott Co., 1948.

2. Bunnell, Sterling M.D.,, "Occupational Therapy of the Hands," *Am. Journ. Occup. Ther.*, 4, 145-153, 1950.

3. Bunnell, Sterling, M.D., "Hand Splints," *Orthopedic Appliances Atlas*, J. W. Edwards, Ann Arbor, Mich., 1952, Vol. 1, 277-326.

ADDITIONAL REFERENCES

Funsten, Robert V., M.D., "Suggestions from the Brace Shop," *J. Orthopaedic Surg.*, 2:345-356, 1920.

Ulrich, F.F.A., M.D., "A Splint for Treatment of Stiff Fingers," *J. Orthopaedic Surg.*, 321-326, 1920.

Hicks, Robert Alan, M.D., "An Adapted Banjo Splint," *J. Bone and Joint Surg.*, 19:252-254, 1937.

Hart, Vernon L., M.D., "A Simple and Efficient Finger Splint," *J. Bone and Joint Surg.* 19:245, 1937.

Oppenheimer, Edgar D., M.D., "Splint for Correction of Finger Contractures," *J. Bone and Joint Surg.*, 19:247-248, 1937.

Marble, H. D., M.D., "Purposeful Splinting Following Injuries to the Hand," *J.A.M.A.*, 116:1373-1375, March 29, 1941.

Schnayerson, Ned, M.D., "A Finger Splint for Extension or Flexion," *J.A.M.A.*, 110:2070-2071, June 18, 1938.

Koch, Sumner L., M.D., and Mason, Michael L., M.D., "Purposeful Splinting Following Injuries of the Hand," *Surg., Gynec. Obstet*, 68:1-16, 1939.

EDITORIAL

EMPLOYING THE REHABILITATED

The nation celebrated "Employ the Handicapped" week from October 4 to 10. Only time will tell how effective this week was in achieving the goals toward which we, as occupational therapists, and all the other workers in the rehabilitation field are striving. However each year will produce some results that eventually will grant the handicapped individual his rightful place in the economic world.

However, irrespective of the extensive educational programs conducted by all medical and rehabilitation workers throughout the year, and the concerted drive made during the week devoted to an all-out program, progress will always be slow as long as our government persists in its own prejudice of employing only the physically normal individual.

In the revised edition of Dr. Kessler's book entitled *Rehabilitation of the Handicapped* he also emphasizes this point.

> "While we belabor society at large, and employers in particular, for their recalcitrance in cooperating toward a more human and efficient use of manpower, one of the chief offenders in this regard is the government. About 3,000,000 workers are employed by federal, state, and municipal agencies. These positions are limited to those 'free from disabling effects.' For years, the routine physical examination that accompanies the employee's application has been considered a farce, since in the average case the examination is usually superficial, performed as a matter of accommodation by most family physicians; and in many cases, serious, though hidden, physical defects are overlooked. Yet the Civil Service Commissions have maintained this fiction of physical perfection of the government as employer, reflects the same prejudices and false concepts of capacity to work as are found among private employers. Emphasis is placed on the defect, and the value of the remaining functional assets is ignored."

Therefore the most logical and effective place to eradicate prejudice against workers with disabilities is to begin in the area where we have some influence, our own government. Through the charity of the government, the disabled are offered medical care and educational opportunities. The government then feels it has discharged its obligation. But in modern society the discharge of duty does not end the obligation. Our responsibility lasts until these people are properly employed in a suitable job and if this job is a government job, no discrimination should be shown. The government can lead the way in convincing other employers of the efficacy of hiring the handicapped. Prejudice and habit are hard to overcome and so it is illogical to expect private employers to readily accept rehabilitated workers when our government continues in its discriminatory manner.

In the modern tenet, a rehabilitated person is one who has been given the proper medical and educational care to do the job for which he has been trained. Care has been exercised in choosing this job so that the person is suited physically and mentally for the requirements of the job. His handicap therefore is not a handicap on the job so it is foolish to discriminate against him in the personnel office whether it be a governmental or private concern.

CALENDAR

October 22-24, 1953
Continuation course in rehabilitation at the Center for Continuation Study, University of Minnesota

October 27, 1953
Postgraduate seminar in psychiatry, Embreeville State Hospital, Embreeville, Pennsylvania

October 30 - 31
Seventh annual meeting of the American Academy for Cerebral Palsy, Western Hills Hotel, Fort Worth, Texas

November 13 - 20, 1953
Annual conference of the American Occupational Therapy Association, Shamrock Hotel, Houston, Texas.

November 9 - 13, 1953
Annual meeting of the American Public Health Association, New York City.

September 12 - 15, 1954
Second International Congress of Cardiology, Washington, D.C.

September 16 - 18, 1954
Annual scientific sessions of the American Heart Association, Washington, D. C.

FEATURED O.T. DEPARTMENTS

Army Photo

OCCUPATIONAL THERAPY SECTION

PHYSICAL MEDICINE SERVICE
BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON, TEXAS

MARY K. BERTELING,
Captain, WMSC (OT)
Chief Occupational Therapist

The occupational therapy section at Brooke Army Hospital was organized in January, 1944. Since the establishment of physical medicine as a major medical service in Army hospitals, the emphasis of the occupational therapy program has been one of definitive functional treatment.

Brooke's present physical medicine service consists of five sections:

1. Administrative and statistical section.
2. Consultation and diagnostic section.
3. Physical therapy section.
4. Occupational therapy section.
5. Physical reconditioning section.

All patients with physical disabilities for whom physical medicine is requested are examined by a physiatrist and the appropriate treatment is then prescribed in any or all of the treatment sections of the service. To insure each section receiving adequate information about the patient and knowing what other treatment the patient is receiving, a copy of the physical findings and treatment prescribed in physical therapy, occupational therapy and physical reconditioning is sent to each section. Occupational therapy for psychiatric and tuberculous patients is prescribed by the ward officer of the respective service and these patients are referred directly to the occupational therapy section.

Since the hospital is composed of four different and widely separated buildings, the physical plant necessitates four occupational therapy clinics. In the largest clinic, which is at Annex IV, 566 functional patients were treated in 1952. The four major disability groups treated were upper extremity fractures and/or nerve injuries, poliomyelitis, upper motor neuron lesions and arm amputees.

The occupational therapy treatment for patients with poliomyelitis is based on currently accepted principles and is varied to meet the needs of the individual patient. In shoulder and arm weakness, the treatment is first directed toward general light exercise of the upper extremity. Slings are used to support the weight of the arms and to allow for motions with the least possible requirement for muscle power. Primary stress is toward achievement of muscle balance over each joint. Leather lacing and cord knotting are activities used for adults, and anagram boards, beads on strings, and sewing cards are used for children. Secondary objectives include strengthening the shoulder stabilizers, the muscles of the rotator cuff and the deltoids. In the pre-crutch walking phase, emphasis is on strengthening the shoulder girdle depressors and hypertrophy of the triceps and the muscles of the hand, especially the lumbricales. Since punching heavy leather has proven effective for strengthening the lumbricales, many of our punches are adapted so that background stamps are mounted in punches to provide long-term repetitious use of hand muscles. If the prognosis is such that normal use of muscles will not be possible, the activities of daily living become the most important part of the treatment program, and feeders and other adapted equipment are used to improve independence.

The program for arm amputees begins in the preprosthetic stage with the patient working toward increasing the dexterity of his remaining hand. When the prosthesis is fitted, the emphasis is on attaining proficiency in the use of the hook and smooth control of the elbow mechanism. After the basic principles have been mastered, the patient practices daily living activities and the use of tools in bilateral craft activities. Patients are graded on an achievement chart and treatment is terminated, by a physician assigned to the physical medicine service, when maximum benefit has been obtained.

For patients with peripheral nerve injuries, occupational therapy is directed toward increasing muscle power, and for patients with upper motor neuron lesions, emphasis is placed on increasing coordination and functional capacity for daily living.

The second occupational therapy clinic is at the main hospital. Since Brooke is an army treatment and research center for burns, patients are

brought here from all over the country for treatment. The occupational therapy program for these patients is designed to increase range of motion and endurance in the burned extremity. Measurements must be taken regularly and functional devices must be adjusted continually so that the patient is at all times striving to achieve a greater range of motion. This may be accomplished by the adjustment of felt padding and rubber sponge on tool handles, the shank length of bicycle devices in knee injuries, the height of beater handles on looms in auxiliary contractures and tool adaptations to increase the web space between the thumb and index finger.

The program for children with cerebral palsy in this clinic is directed not toward the daily treatment of these children, but toward the instruction of the parents in home training procedures. The children are seen by the physiatrist and the physical and occupational therapists at regular intervals; the progress is evaluated and the home program is changed as indicated.

The closed ward neuropsychiatric clinic is on the ground floor of a building only a few yards from the hospital building, with Red Cross and the physical reconditioning unit occupying the second floor. Leatherwork, weaving, woodwork, plastics, metalwork, ceramics and painting are the main craft activities. Needlework, knitting, stencil and other minor crafts are additional activities used in the treatment of women patients. However it is not the activity which is stressed here as much as the attitudes assumed by the therapists and the attending personnel. Rapport is absolutely essential and proper patient-therapist relationships must be established before any activity can be successful.

Prescriptions are sent directly from the psychiatrist to the occupational therapy section and the program is directed toward the treatment of acutely ill patients, many of whom are receiving shock therapy, and other short-term psychiatric patients such as the depressed, the excited and the schizophrenic. Long-term patients are not kept in Army hospitals but are sent to state and Veterans Administration hospitals for treatment. Recreational and athletic programs are the responsibility of Red Cross and the physical reconditioning unit, except for gardening which is an occupational therapy activity.

The fourth occupational therapy clinic is in Annex III and is for the treatment of open ward neuropsychiatric patients, who are housed in this building. Although this clinic is small, the same variety of activities is used as in the other larger clinics. The occupational therapy program in this clinic is part of a total push program which includes psychiatric treatment, occupational therapy, physical reconditioning and work details. Certain neurological patients are also treated in this clinic and the aims with these patients are to improve coordination and help the patient become more self-sufficient in the activities of daily living.

Army Photo

Physical education class of Southwest State Teachers College visits occupational therapy section.

A small ward program is carried on in Annex IV for the tuberculous patients and certain functional patients. The functional cases are usually poliomyelitis patients who are not yet ready for treatment in the clinic or patients with an upper extremity injury who are confined to bed by an additional illness or injury. The program for tuberculosis patients is entirely a ward program since most of these patients are awaiting transfer to a tuberculous treatment center. Light craft activities of many kinds are used to provide relaxation in the initial stage of bed rest and to control the patient's physical activity at a rate commensurate with the stage of the disease.

Because Brooke is a treatment center for general and orthopedic surgery, amputees, neurosurgery, plastic surgery, neurology, and closed and open ward neuropsychiatric patients, the number and variety of cases treated here are exceptional. Physicians and dentists are assigned here for residencies and internships, refresher courses are often held for Army and Air Force medical officers; dietitians, physical therapists and occupational therapists are assigned here for their clinical affiliation. Consulting physicians make regular visits to the hospital and a teaching program is carried on at all times.

The physical medicine staff at Brooke is a large one: five physiatrists, twelve occupational therapists, seventeen physical therapists, two reconditioning officers, and thirty-eight enlisted technicians are assigned to the service. Twenty-two thousand patients received treatments in physical medicine in 1952 and of these, 5,634 patients

(*Continued on page* 238)

PEOPLE YOU SHOULD KNOW

JOHN D. REDJINSKI, O.T.R.

Biographical Sketch
by
NANCY F. BROWN, O.T.R.

Many occupational therapists know John Redjinski as a highly qualified and competent member of his profession, but few are aware of his special qualifications for his new position. As the recently appointed chairman of publicity, he brings an impressive record of background and experience in reporting and other newspaper work. In fact occupational therapy can consider itself fortunate in having this combination of talents upon which to draw in furthering its publicity efforts.

John was born in Milwaukee, Wisconsin, and attended Messmer High School where he was on the debating team, the school paper and an "on the fringe" athlete. He next attended St. Mary's College in Wisconsin where he continued with athletics and branched out to writing a daily college sports column for a local paper as well as other news material. While at Marquette's School of Journalism he did more free-lance sports reporting for several Milwaukee newspapers and for the college publicity department.

Then followed the depression years during which John held various positions including operating a dispensary in the Civilian Conservation Corps, and working as a hospital orderly. He joined the Army in 1936 to see the world and managed to cover a good deal of it in the following years. While at Fort Sheridan, Illinois, he edited the "Fort Sheridan News" and was post librarian. Then, following a brief look at civilian life in 1939, he re-entered active service in January, 1941, with the 135th Medical Regiment. He rose from first sergeant to master sergeant and became chief clerk in the Surgeon's Office, Port Moresby, New Guinea, and did admitting and evacuation work with the 42nd General Hospital in Brisbane, Australia. After 30 months of overseas duty he returned to the United States in late 1944 and after a brief tour of duty in this country was discharged in 1945.

John entered the occupational therapy course at the University of Wisconsin in October of that year and, with the encouragement and assistance of his wife, was graduated in 1948, completing his clinical training at the Menninger Clinic in Topeka, Kansas. He continued working there for a stimulating year and a half before accepting his present position as chief of occupational therapy at the Veterans Administration Hospital in Tomah, Wisconsin. Among his many interests has been the development of a special exhibit room at his hospital and the evolution of an integrated and varied program for hospital publicity through exhibits.

John's background in reporting and newspaper work has eminently qualified him for the position of chairman of publicity. The value of his contacts was ably demonstrated during the 1953 national conference in Milwaukee when he was responsible for much of the fine publicity provided by the newspapers and radio stations. The stimulus of his leadership and ideas should provide a valuable increase in the publicity for and interest in occupational therapy at a time when the field urgently needs new recruits and wider dissemination of knowledge.

John is ably supported in his work by his wife, Fran, whom he married in 1941, and has two potential occupational therapists in his daughters, Catherine, six years of age, and Barbara, three years old.

AOTA bills for 1954 will soon be sent. By paying promptly you will be assured of receiving your AJOT without delay. It takes time to process so many bills at one time, therefore cooperate with the AOTA office and pay promptly. Also note that the bill carries a special section at the bottom for mailing information about AJOT. *Do not tear this off,* but fill out the form and return the entire sheet.

Committee Reports

AMERICAN OCCUPATIONAL THERAPY ASSOCIATION

MEETING OF THE BOARD OF MANAGEMENT

Hotel Muehlebach, Kansas City, Missouri

March 15, 1953

The Board of Management meeting was called to order at 9:15 A.M. by the president, Miss Henrietta McNary.

Roll Call and Proxies

Members Present:	Miss Maxine Ferrell
Miss Henrietta McNary	Mrs. Marian Beauchamp
Major Ruth A. Robinson	Proxies held for:
Miss Clare S. Spackman	Miss Marjorie Taylor
Sister Jeanne Marie Bonnett	Miss Marian Davis
Miss Patricia Exton	Mrs. Elizabeth Jameson
Miss H. Elizabeth Messick	Dr. Walter Barton
Miss Beatrice Wade	Dr. William R. Dunton, Jr.
Capt. Wilma West	Mrs. Eleanor Owen
Miss Carlotta Welles	Mrs. Louise Wade
Dr. Sidney Licht	Not Represented:
Miss Marguerite Abbott	Dr. Freemont A. Chandler
Miss Shirley Bowing	Dr. Arthur C. Jones

Minutes of the Previous Meeting. The minutes of the annual meetings held at Hotel Schroeder, Milwaukee, Wisconsin, August 11 and 14, 1952, were accepted as distributed by mail.

Report of the Treasurer. Financial statements and budgets for general and educational funds, and the final Grant Foundation account were distributed to all Board members at the meeting. Miss Spackman reported that at this mid-year period the approved budget for the 1953 fiscal year looked satisfactory. She called attention to income from registration fees which will exceed the estimated amount and membership fees which were already over the estimated amount.

The treasurer indicated particular rise in costs for the audit and Year-book mailing. The Association is now carrying a Workmen's Compensation policy covering injury to employees while at work.

The Board voted that the scale of salary ranges for professional and secretarial staff, as they appear in the AOTA office personnel policies, be increased.

The Board voted an increment each two years for professional staff for good service with the proviso that the budget has the money available. Revised salary ranges and increments to become effective September 1st, 1953.

The Board voted to transfer $10,000 from our cash reserve into a savings bank thus earning approximately $250.00 interest per year.

The treasurer's report was accepted with thanks and gratitude.

Report of the Educational Secretary. Since the full report had been distributed to all Board members prior to the meeting, Miss Matthews presented a summary.

A description of the finished product of the student selection instrument was given. The $491.00 balance from the Grant Foundation fund is to be used for a follow-up study to strengthen the reliability of the instrument by retesting the last group of students in clinical training. It is not expected that the above sum will cover total costs.

The committee for the evaluation of occupational therapy departments has not met with the national office staff since the 1952 conference. A sum of $250 to $500 was indicated as needed to enable this study to progress satisfactorily.

The plan for special services to schools was reported with the majority preferring to be billed for each service, some specified payment of a blanket fee, a few have not indicated. Services rendered, or in preparation, include mimeographing and mailing the minutes of the education committee of the 1952 conference, analysis of the June, 1951, and February, 1952, registration examinations as part of the complete data of every fourth administration; analysis of the 1952 clinical training reports.

100% cooperation of OT schools was reported in conjunction with the schools questionnaire which was part of the NFIP study on personnel shortages in the fields of OT, PT, and Medical Social Work. Results of this survey were distributed at the Board of Management meeting.

The Board voted that a letter of appreciation be sent to Dr. Brandt for his work on the student selection instrument form.

Report accepted with commendation.

Report of the Executive Director. A complete report of activities for the first half of the year was distributed to all Board members prior to the mid-year meeting and the report is being printed in AJOT. These minutes will record only those items on which Board action was necessary.

A small complimentary mailing list of national organizations has been established for the Newsletter as a good public relations channel. The Board was asked to approve the principle of this plan for continuance and expansion. Opinion was expressed that the Newsletter should not be geared to any other group or lose its focus on membership. A complimentary mailing list can be a challenge to us to interpret our services in a dignified way and show our growth and a consciousness of the public. The Board voted that the Newsletter continue to be sent to other organizations until such time as the list reaches 100 with further consideration at a later date when that total is reached. The Board suggested that an explanatory note might accompany the complimentary copies indicating that the Newsletter is "published for members of the AOTA" and mentioning the American Journal of Occupational Therapy as another publication of the Association.

The $16,000.00 budget and designed program for carrying out an intensive recruitment campaign in 1953, made possible by the grant from the National Foundation for Infantile Paralysis, was circulated to all Board members in advance of the meeting. The Board voted that the budget be accepted and approved the plan which will be carried out with Bonner and Newman, public relations consultants, in conjunction with the AOTA Office, publicity and recruitment committee, state recruitment chairmen and accredited schools.

The Board was informed that the Executive Committee had voted our application for membership in the National Health Council. They were authorized at the August Board meeting to give further consideration to this.

Report accepted with grateful recognition of the accomplishments which it represented.

Report of the Speaker of the House of Delegates. A detailed report by the Speaker of the House of Delegates follows so a summary is not included in this report.

Report of the Editor of AJOT. Mrs. Murphy presented an interesting report on AJOT progress to date and the following actions were taken.

The first Buyer's Guide was printed as Part II of the March-April issue. The Board voted to continue the Buyer's Guide as a Journal service.

The Board voted that the Yearbook continue to be included in an 8-time advertising schedule to be sold until the first of the year, after which time the Yearbook advertising will be solicited by the New York office on a 1-time basis.

The Board voted that the Yearbook be sent as proof of publication to full page and half page advertisers. Smaller advertisers will receive tear sheets only. This new policy is to discourage advertisers from taking the ad to get a free mailing list which definitely hinders Journal advertising.

The Board voted that all advertising commissions be placed on the 25% rate which is standard. There had been approximately six still carried at 15% which was the rate used when AJOT changed hands.

The Board voted to maintain the 4400 edition of AJOT which includes the customary 200 annual increase. This leaves a backlog of several hundred copies in the New York office where the storage problem is acute, but it was felt that this was not too great a margin. The Board suggested that effort be made to publicize availability of back numbers and volumes for sale through the Newsletter, House of Delegates and a special box in AJOT.

The Board authorized the editor to use her own judgment and discretion relative to reducing or eliminating sections in the back of the magazine which is becoming necessary due to the addition of new features.

The Audit Bureau of Circulation sought our subscription to their facilities. The Board agreed with the editor that we are not yet ready to undertake the procedures and expense involved.

The Board recommended against running advertising pages in the back of the magazine opposite reading material.

Report accepted with appreciation and admiration.

REPORT OF CHAIRMEN OF STANDING COMMITTEES

Education Committee. Miss Willard reported the reorganization plan of the education committee which creates a new central committee within the education committee (composed of school and clinical training directors) which will be responsible for the establishment of educational policy with Board approval.

The committee on graduate study urged 1) inclusion of AJOT in the *Readers Guide* (pub. by H. W. Wilson Co.), 2) service of AOTA education office in correlation of a survey to determine the nature of graduate work done, availability of results, identification of students for graduate study, 3) standardization of graduate study to be achieved on the basis of the present pamphlet, *Essentials for O. T. Schools.*

The subcommittee on schools and curriculum suggested establishment of a national occupational therapy Research laboratory for the testing of adapted equipment and devices. It is recommended that a committee be formed to study the possibilities of financial support.

The subcommittee on clinical practice recommended evaluation of the performance rating form to be used experimentally with the clinical training report form for one year as a research project in student rating.

They further recommended that at the earliest possible date an open session on clinical training be planned as a part of the program at the AOTA annual conference since clinical training is a subject of general interest.

There has been correspondence from four schools regarding the establishing of O. T. courses: Universities of Buffalo, North Dakota, Oklahoma and the State Insurance Fund in Puerto Rico. Alverno School of Music has never made application.

The following committee assignments were announced: definitions, O.T. curriculum guide, SOP for Education committee, SOP for school directors, AMA *Essentials* and AOTA standards.

The education committee made the following recommendations:

1. a. Continued study of the shortened curricula (5 to 4 yr. degree course) in the school.

b. Consideration given to limiting or reducing the number of clinical training centers, i.e. develop larger teaching centers and fewer small scattered ones.

c. Clinical practice subcommittee should state the minimum number of manual activities they think essential for the training of students, state whether they would be willing to teach skills not covered in the academic phase, and if so, which ones and how many.

2. That the president appoint a small committee to study the Veterans Administration directives to executive assistants and to state wherein they seem unsatisfactory to us, specifically from the educational angle. A letter will then be sent directly to Admiral Boone asking for a meeting with VA representatives to discuss the matter. The blanket acceptance of aides is to be mentioned in the letter and the principle is to be discouraged.

The Board voted that such a letter be sent.

It was recommended and voted by the Board that an official letter go from the president to the AMA council on medical education and hospitals calling attention to the fact that the present accredited schools curricula could easily be adjusted to give the necessary medical training to persons already qualified in skills, such as manual and industrial arts, fine arts, home economics, music, education.

It was recommended that a small group of medical advisors to the Association be appointed. Board action on this is reported in these minutes under "Other Business."

It was voted by the Board that protest be made by the president to the AMA relative to the new practice of approval of O.T. schools prior to full operation of a program and to seek clarification for the future regarding tentative approval of a program versus accreditation of a curriculum.

Report accepted with appreciation.

Registration Committee. Miss Matthews distributed copies of her report to all Board members. No action was required.

The registration committee has devoted considerable time to the review of the two older parts of the examination and drastic trimming resulted.

International reciprocity policies, as approved by the Board, and published in AJOT, Vol. VII, No. 1, 1953, were sent to the official occupational therapy associations in nine countries.

The March-April issue of AJOT carried the first published list of examinees who successfully write the registration examinations. The five highest scores will be marked with an asterisk.

Report accepted with thanks.

Permanent Conference Committee. Mrs. Kahmann reported a plan for reorganization of this committee made necessary because our conferences are becoming too large for one person to handle. The committee will comprise five subchairmen supervising program, exhibits, hospitality, registration, publicity, with the president, editor, executive director, educational secretary, and local conference chairmen as ex-officio members.

The prepared standard operating procedure for the conference is being revised and will be presented to the Board for approval at the 1953 conference.

The 1954 conference in Washington, D. C. will be handled by Maryland, Virginia and Washington, the former responsible for the general convention program and the latter for the institute.

The 1955 conference will be held in San Francisco, October 17th-22nd. The Board voted to accept with pleasure and thanks, the invitation of the Minnesota O.T. Association to meet in Minneapolis in 1956.

Report accepted with thanks.

Special Studies Committee. Miss Gleave reported on the purposes and plan of reorganization of this committee which will give it a somewhat different slant than previously. The purposes are to conduct studies, to discover and interpret new facts and to apply these in a practical manner to treatment programs. The plan of organization calls for a central steering group, guidance from a qualified source as to the proper methods of accumulating these facts, and analyzing the material.

The Board voted to accept the proposed plan for organization and research. They further voted that there be subcommittees representing each of the major diagnostic areas.

Report accepted with thanks.

Legislative and Civil Service Committee. Miss Fish read Mrs. Wade's report in her absence which stated that there had been little action since she took the chairmanship late in the year.

Miss Fish supplemented the report as follows:

1. Connecticut stated they had established an advisory council which had successfully met and the licensing problem appeared to be settled to the satisfaction of all.

2. Minnesota reported that the state legislature planned recommendations that would decrease the number of occupational and recreational workers in mental hospitals and use funds to increase the number of psychiatric aides.

3. Rhode Island reported a proposed pay scale change in state civil service based on a new "point evaluation" system, which will produce an inequity unfair to occupational therapists with a consequent lowering of professional standards. The AOTA Office sent a letter registering protest to the governor, personnel administrator and budget director of Rhode Island.

Report accepted.

REPORT OF CHAIRMEN OF SPECIAL COMMITTEES

Recruitment and Publicity. Miss Fish read Mr. Redjinski's report in his absence which stated that his first several months had been spent in orientation and the evaluation of the recruitment situation. Activities and accomplishments of the committee and recruitment programs of related organizations have been carefully studied. Six areas of effort have been selected for concentrated attention and state chairmen were advised of these areas in the first of a series of Newsletters. These areas are: person-to-person contact; more parent contact; contact with lower age groups; recruitment of men; small towns and rural area acivity; more student participation.

The chairman requested individual assistance of Board members in the following: (1) Inform recruitment chairman of articles and communications relating to the critical need for therapists, (2) Encourage doctors and medical leaders to express, in their writings and speeches, their conviction of our critical need for personnel.

Report accepted with appreciation.

Committee on Occupational Therapy in Psychiatry. Miss McNary read the report in Miss Ridgway's absence. The major activities have been solicitation, assembly and review of material for the special psychiatric issue of AJOT; appointment of representatives from the psychiatric field to provide the AOTA Office with information (literature, policies, meetings) of other organizations; appointment of an advisory group of experienced psychiatric therapists to meet together as a central planning group for the total committee which has lacked productivity due to its temporary status.

The Board discussed the difficulties encountered due to the large committee membership and scattered geographical areas resulting in a bogging down of organization. Consideration was given to placing the psychiatric committee under the special studies committee as one of the diagnostic areas.

Report accepted with appreciation.

World Federation of Occupational Therapists. Miss Spackman reported that with the official establishment of the WFOT, her international committee was automatically abolished. The AOTA has applied for and been accepted as a member country in the World Federation. In the U. S., we have twenty-seven individual members, eight individual subscribers, one contributing member. The constitution of the World Federation provides for two alternate delegates from each member organization. Appointment of a second alternate from the United States should be made.

Report accepted.

Committee on O.T. Definition. This report was included in the education committee report as prepared by the chairman, Miss Patricia Laurencelle. Full report on definitions will be circulated to Board members.

Committee on Officers-elect. Major Ruth Robinson, chairman, submitted the following recommendations:

1. That the president be elected at the annual meeting, one year prior to taking office, and that during the ensuing year he serve as a non-voting member of the Board and of the Executive Committee.

2. That the treasurer be elected at the annual meeting, one year prior to taking office, and that during the ensuing year he serve as a non-voting member of the Board, of the Executive Committee and as an apprentice treasurer. It was suggested that consideration be given to the election of a treasurer from those members of the Association who live within easy traveling distance of the AOTA office.

3. That the chairman of the nominating committee continue to be appointed by the president, no later than one month following the annual meeting, rather than making this an elective office.

4. That the past-president serve as a non-voting member of the Board of Management for a period of one year after leaving office.

The Board voted approval of the recommendations on the president-elect and the treasurer-elect. The Board voted that the House of Delegates shall elect the chairman of the nominating committe from the membership at large. The chairman will appoint her own committee members and it was suggested she be a person well acquainted with the membership.

The Board voted that a constitution revision committee be established for the purpose of effecting the necessary provisions in the constitution.

Report accepted with thanks.

Standard Operating Procedure for AOTA Committees. Capt. Wilma West, Chairman, outlined content of her report which included a summary of each Association committee, identification of standing and special committees, procedure for reporting and dissolving of committees, inter-relationships of all AOTA committees by an organizational chart.

The Board suggested that this report be mimeographed and sent to all Board members for study and comments and that it be presented, again, at the 1953 conference.

Report accepted with thanks.

OTHER BUSINESS

The Board recommended that a small committee be appointed to review the manual entitled *OT Volunteer Assistants Training Course* and suggest revisions for reprinting.

The 3-year terms of the majority of Fellows of the Association expire this year and it was indicated that thought should be given to the names of incoming Fellows. The Board voted that a study be made relative to defining the function of Fellows in relation to a medical advisory group as recommended by the education committee. It was voted to place this study in the hands of a committee which would report at the 1953 conference. It was suggested that the following be included in the recommendations: (1) Fellows should be selected who have an interest in, and knowledge of occupational therapy (2) their appointment should be contingent upon intention to attend at least one meeting yearly (3) they will be expected to act as consultants through correspondence.

The Board approved the suggestion that the educational secretary sit in on Board meetings.

A letter was read from the American Physical Therapy Association in reply to our inquiry seeking clarification regarding the rumor that they were urging joint licensing in states. The association stated that they understood and were appreciative of our stand on licensing and that there had been no action on their part to encourage joint licensing.

NEW BUSINESS

1. Considerable discussion was devoted to the proposed liaison committee for rehabilitation personnel relative to which letters were received from the American Association of Rehabilitation Therapists (manual arts and educational therapists) and the Association for Physical and Mental Rehabilitation. We were invited to participate in the formulation of plans for the establishment of a professional association of medical rehabilitation personnel.

The board indicated that they did not consider such a liaison feasible at this time, particularly in view of the forthcoming conference being convened by the National Rehabilitation Association in which all of the national organizations concerned with rehabilitation were participating..

The Board voted that the AOTA approach other professional organizations comprised of accredited and appropriately trained medical personnel (American Physical Therapy Association, Associations of Medical and Psychiatric Social Workers, American Association of Psychologists, American Speech and Hearing Association) relative to the possible advantages and disadvantages of forming a council for the purpose of interprofessional coordination relative to maintaining high levels in standards and patient care.

2. The Board voted that a committee be appointed to make a study and report at the 1953 conference relative to recommendations for proposed standards of training, accreditation, and recognition of non-registered personnel (OT assistants and aides) in the OT program. This study is to consider the re-establishment of an auxiliary registry.

3. The Board instructed the executive director to proceed, with the backing of the Executive Committee, relative to informing the membership of national issues and to use the several channels at our disposal, i.e. Newsletter, AJOT, Delegates.

4. A letter was read from the National Conference of Social Work again inviting us to apply for associate or special group status which brings with it the advantage of joint program planning and participation in the annual conference. The Board voted that the AOTA take a special group membership.

5. A letter was read from Dr. Walter Barton tendering his resignation as a Fellow on the Board, this action being necessitated by heavy pressure of other duties. The Board accepted his resignation and instructed that a letter be sent to Dr. Barton expressing great regret and sincere commendation with the hope he would be willing to continue as a Fellow of the Association and that appropriate publicity be given to his outstanding contribution as a Fellow on the Board.

6. A letter was read from Miss Carlotta Welles stating that she planned to be present at the meeting of the World Conferedation of Physical Therapy in London, September, 1953, and would be glad to represent the AOTA. The Board expressed appreciation of this and designated that she be appointed our official representative if an invitation for such representation was received from the Congress, otherwise she would serve to bring greetings.

As a time saver, it was recommended that all committee chairmen be asked to submit summary reports to be mimeographed and sent to the Board with advance materials preceding the 1953 conference.

There being no further business, the meeting was adjourned at 5:30 p. m.

Respectfully submitted,
MARJORIE FISH, O.T.R.
Executive Director.

Note to membership: It is felt that the mid-year report of the House of Delegates to the Board of Management contained pertinent material of such interest to the membership that it is being included with the report of the Board of Management for your information.

REPORT OF THE SPEAKER OF THE HOUSE OF DELEGATES

REPORT OF SPECIAL CHAPTER COMMITTEE OF THE HOUSE

Initial Presentation. Contingent upon and at the request of the Board of Management of the American Occupational Therapy Association and pursuant to action taken at the annual meeting of the House of Delegates, August, 1952, at the AOTA conference at Milwaukee regarding the formation of chapters, the following action was taken:

It was voted: (1) that a special committee from the House of Delegates be appointed to study the problem of chapter formation and to present the facts to the delegates for further clarification and study after presentation of the facts to the Board and (2) that a committee was to start immediately in order to present such a report to the mid-year board meeting for their considered opinion and further recommendations.

Basic Organization of Committee Work:

1. Chairman: The speaker of the House assumed the chairmanship of this committee.

2. Areas: For greater committee flexibility the country at large was divided into eight temporary areas. These area divisions are for temporary committee use and are not to be confused with permanent designation of O.T. state divisions.

Committee Memberships. There are nineteen committee members, including the chairman, selected on a nationwide basis.

Cover Letter. For clarification a cover letter was sent to all committee chairmen, delegates, presidents of state associations and executive members of the American Occupational Therapy Association Board of Management including the following:

1. Some basic reasons for a fact-finding committee regarding state chapters.

2. A survey form to be used as a recommendation, not a directive, from the national office to ascertain the desires and wishes of the membership at large.

3. Statement of some of the basic issues.

Results of the Survey

The following data was compiled from the chapter committee report.

1. Those in favor of chapter divisions	16
2. Those in favor with reservations	5
3. Those not in favor	6
4. No report	5
5. Pending	3
TOTAL	35

Summary of Issues

1. All state associations agreed in principle that some reorganization of state associations be undertaken to include the smaller groups unable for various reasons to attend the state association meetings. These smaller groups might take the form of "districts," still keeping memberships in their state O.T. associations.

2. Most states wanted to keep the present organizational structure but to amend the constitutions to permit "districts" (preferring the word "districts" instead of "chapters") to be formed from those groups that may petition the local state association for district membership.

Suggested Recommendations

1. Each state O.T. association to amend its present constitution to allow the formation of districts which will belong to the state O.T. association in their area. It is not mandatory for the states to have districts.

2. Redefinition of the word and status of the term "associates." That another category be created in the membership classification to include non-registered O.T. therapists now known as "associates." This new category to be designated, perhaps, as "O.T. assistants" or "seniors" and referring to the O.T. staff members now working in O.T. departments, but not registered.

3. That the secondary register be reopened, or another register be created to be called, perhaps, an auxiliary register. This new category of "O.T. assistant" to be admitted, pending the successful passing of an examination to be set up at his functioning level, by the American Occupational Therapy Association with the rights, privileges and franchise to be designated by the national and state associations. Furthermore, "O.T. assistants" would be known for what they are, but would not be eligible to hold state or national office, but would have franchise for voting for the delegate who would represent them. It would seem from the above report that we have not only a statewide but a nationwide problem in the extenuating situation which is the result of our own professional deficit of registered therapists. Not being able to meet the demand for registered therapists in the field, an auxiliary register will not only help some state situations but will also point the way for a united front.

Action Taken: Steps will be taken by the American Occupational Therapy Association to re-establish an auxiliary register, and proposals will be made of standards for training, accreditation and the use of non-O.T.R.'s in the O.T. program. A report on this is to be given at the 1953 conference.

NATIONAL NOMINATING COMMITTEE

Twenty-one state O.T. associations were in favor of having the yearly American Occupational Therapy Association nominating committee as an elective rather than appointive office.

DELEGATE NEWS LETTER

A periodic delegate news letter is being sent out as a means of keeping the house membership informed as to pertinent and current basic issues and changes of policies.

Respectfully submitted,
Marguerite Abbott,
Speaker of the House.

DELEGATES DIVISION

CONNECTICUT

Delegate-Reporter, June Sokolov, O.T.R.

While very few purposes or goals were formalized at our early meetings during the past year, it is of interest to note what areas of activity have been emphasized by the Connecticut Occupational Therapy Association since September, 1952.

By popular demand it was decided to rotate meeting places so that all members might gradually become familiar with their colleagues' departments. The association also voted to hold general meetings every other month and executive committee meetings alternately, with the exception of December. In accordance with this plan the first general meeting took place at Hartford Hospital in the department of physical medicine and rehabilitation, the second at Grace -New Haven Hospital in their department of physical medicine and rehabilitation, the third at Newington Home and Hospital for Crippled Children and the spring meeting, by tradition, in conjunction with the annual State Medical Society meeting at Hamden High School, Hamden, Connecticut.

Because of a serious concern with the issue of licensure of occupational therapists in Connecticut, the executive committee, at the request of the membership, arranged for an advisory board comprising five members: Edgar Yerbury, M.D., Superintendent, Connecticut State Hospital, Middletown; Berger Foss, Director, Newington Home for Crippled Children and Adults; David Boynick, Joint Commission on Mental Hospitals; Thomas F. Hines, M.D., Chief, Department of Physical Medicine and Rehabilitation, Grace-New Haven Hospital; and Maurice Cronan of the Hartford Courant Newspaper. This group convened and conferred frequently with the executive committee after preliminary material concerning our problems had been distributed to them. They have been most gracious with time and advice, and the group has felt deeply satisfied with their decision to establish the advisory board which will continue to function in the coming year.

In connection with the above report, members of other associations will welcome the news that occupational therapists were not included in the revised bill licensing physical therapists that was approved in the Connecticut legislature this year.

Recruitment has been the focus of considerable effort during the past year. The current chairman solicited and collected a very complete set of colored slides depicting occupational therapy as it functions in the various fields. These have been used quite extensively in the presentation of occupational therapy as a career to various school groups. For the most part the slides have been donated as a long-term loan by many hospitals and clinics in the state.

In connection with the development of the National

Association of Rehabilitation Therapists, Connecticut has been in touch with the New York Occupational Therapy Association and our membership has been alerted to certain inadequacies and infringements of sound professional principles as established by our A.O.T.A.

In an attempt to increase our revenues, it was voted to increase annual membership dues and at the February, 1953, general meeting the by-laws were amended to permit raising present dues for active members from three to four dollars yearly and those for association members from two to three dollars. This increase becomes effective January 1, 1954. In addition, this year has seen the inauguration of a raffle at each general meeting which has supplemented the treasury by as much as $20 at a single meeting.

This season witnessed the appointment of a regular placement chairman. Miss Frances T. Miller, chairman of membership, was asked to assume this additional duty by the president. Miss Miller has been active in soliciting new members and this has accounted for a steadily mounting number of active therapists.

At the spring meeting, the Occupational Therapy Association met in joint session with the Physical Medicine Section and had the pleasure of hearing Dr. Morris Grayson discuss the goals of psychiatry in rehabilitation.

In laying tentative plans for the year ahead, considerable interest was evidenced in a plan for joint occupational and physical therapy association general meetings. There have been many requests for more varied and interesting programs of the workshop or institute type and it is felt that this is only feasible if a good attendance and planning group is assured. This also seems to be a relatively simple method of cementing professional relationships and handling legislative problems of mutual significance.

Greetings to our friends from Connecticut wherever they have roamed.

OFFICERS

President	Alice Rogers, O.T.R.
Vice-President	Mildred Sleeper, O.T.R.
Treasurer	Anne Drag, O.T.R.
Corresponding Secretary	Mary Fiorentino, O.T.R.
Recording Secretary	Suzanne Griselle, O.T.R.
Alternate Delegate	Frances Miller, O.T.R.
Members-at-Large	Marguerite Cavanaugh, O.T.R. Ruth Dalton, O.T.R.

COLORADO

Delegate-Reporter, Gayle Thelander, O.T.R.

Officers elect:

Since 1950 much of our efforts have been in writing and publishing our book, *At Your Finger Tips*. Through this endeavor we plan to finance a scholarship fund for an occupational therapy student. This project also gave other objectives such as an increase of interest to allied fields and a financial incentive for recruitment besides making our profession, in part, known to the public. We are pleased to report that the first edition has been exhausted and the second edition has been published and is on the market. The second edition has been re-edited and offers much more valuable material.

At this time we would like to express our appreciation for all of the interest and cooperation we have received in this publication. We are pleased with its acceptance by our fellow therapists and hope it will give all of you as much joy as it has been to make it available to you.

New departments and additions to departments have been established in the last year. At the State Mental Hospital in Pueblo, Colorado, a new rehabilitation building has been added. This includes an extensive occupational therapy department which our members were able to visit for one state meeting. Another new department is in connection with the Mesa Vista Sanatorium in Boulder, Colorado. This hospital has a government contract for treatment of Navajo tuberculosis patients. This program includes several teachers, as most patients are anxious to learn to read and write both Navajo and English; an occupational therapist, Mrs. Margaret Davies; and two home economists.

OFFICERS

President	Marjorie Ball, O.T.R.
Vice-President	Major Ruth Robinson, O.T.R.
Recording Secretary	Mrs. Marjorie Ormsby, O.T.R.
Corresponding Secretary	Gayle Thelander, O.T.R.
Treasurer	Alice Hill, O.T.R.
Alternate Delegate	Josephine Davis, O.T.R.

HAWAII

Delegate-Reporter, Jean E. Styles, O.T.R.

The May meeting of the Occupational Therapy Association of Hawaii was held in the delightful setting of the Mabel Smyth Lounge on April 24, 1953. The meeting was moved to this earlier date because of the arrival of Miss Martha E. Matthews, education secretary for the American Occupational Therapy Association. Thus all the attending members were afforded the opportunity of meeting and talking to Miss Matthews. The association was sincerely honored with her presence at this time as it was the first official visit of a representative from the national office in fifteen years.

After a brief business meeting Miss Matthews spoke to the group on the work of the national office and advances the educational section is making to improve professional standings. She stated also that because of marriage there are many withdrawals from the profession leaving a marked shortage of therapists, and that there had also been a decrease in enrollment of students. There are five hundred vacancies in schools of occupational therapy and many positions unfilled; therefore it is necessary to seek trained and suitable personnel to fill these positions.

Miss Matthews spoke of her work in the mechanical evaluation of students especially during clinical training periods. She felt that her work in her present position has and is continuing to be a gratifying experience.

During the social hour that followed, refreshments were served, and Miss Matthews had the opportunity to talk with individual therapists.

On May 23 the delegate met Miss Henrietta W. McNary, O.T.R., at Pearl Harbor, Hawaii, on her arrival aboard the USNHS *Repose*. Miss McNary was the guest of the Secretary of the Navy and the 9th Naval District and with a group of thirteen other professional and lay women toured naval and marine installations on the Island at which time, Miss McNary was detached from the group so that she might observe more closely the occupational therapy program and the physical medicine program.

Graduates of Milwaukee-Downer College, living on the island, entertained Miss McNary with a Hawaiian beach picnic on May 28. Everyone enjoyed the spirit of the occasion and Miss McNary even tried her hand at eating poi which is one of the native foods. Complete with a full tropical moon shining on the water, it was truly the perfect setting for a typical Hawaiian affair.

The Willows was the setting on May 29 for a dinner given in Miss McNary's honor by the Occupational Therapy Association of Hawaii. At that time she addressed a few brief and informal remarks to the group as a whole. Later she was able to meet the members individually, renew acquaintances and discuss any matters and/or problems.

The association has been most pleased, honored, and gratified to have both Miss McNary and Miss Matthews

as guests. It is felt that their presence has made the association feel a closer relationship with the national office and that in turn the guests have become better acquainted with the local association. It is hoped that in the future more officers and officials will be able to visit and be guests of the association.

OFFICERS

President	Mrs. Esther Castle, O.T.R.
Vice-President	Mrs. Alyce M. Dahlgren, O.T.R.
Secretary	Mrs. Mi Sun Hong, O.T.R.
Treasurer	Mrs. Violet Kam, O.T.R.
Delegate	Lt. Jean E. Styles, O.T.R.
Alternate Delegate	Miss Catherine Nourse, O.T.R.

IOWA

Delegate-Reporter, Maxine Ferrell, O.T.R.

The Iowa Occupational Therapy Association continues to hold three meetings per year. Since our membership is small and geographically scattered, we feel that most of us can manage to attend each of these meetings. Our membership remains much the same although many vacancies still exist in Iowa. We have 25 active members, 11 state active members, and 6 associate members.

Two major constitution changes were made by Iowa since the last report to AJOT. We feel that these changes have helped us considerably and perhaps may be of benefit to other small associations. First, we established a "state active" membership group to include those registered therapists who are no longer working in the field of occupational therapy. These members pay smaller dues and their membership is encouraged. We believe that these members can be immeasurably helpful to us along the recruitment and publicity lines. The second change which we made has enabled us to solve several problems. We now have our officers elected for two-year terms. This has proven much more satisfactory and it gives the officers time to put some concrete programs into effect.

During 1953 Iowa placed emphasis on two main goals: 1. To increase our financial position. 2. To spread occupational therapy throughout the state of Iowa by increasing our publicity and recruitment. Two main projects served to increase our treasury to amazing proportions. Most successful was the rummage sale which was conducted by the therapists at the State University of Iowa. This proved so successful that we now plan to make it an annual event. Rummage is collected at each meeting. The other project was the sale of a beautiful ladies handbag which was a cooperative project among the Des Moines therapists. All material was donated so that we realized a large profit from this one item. Recruitment was emphasized through the usual channels of contacts with the schools, exhibits, speakers and newspaper articles. We felt that since little is known in Iowa about occupational therapy that it would be best to contact a wide variety of groups at various age levels. We held exhibits at the Iowa State Medical meeting, the Iowa State Fair and at several libraries during the year. We have tried to assemble a permanent exhibit of pictures but this project will involve a great deal more work before it will be completed. Our series of seven tape recordings for radio programs contains some excellent material which can be used in school vocational counseling courses. These tape recordings may be loaned to any other state groups or individual desiring them. They cover a wide range including: the academic preparation for occupational therapy; occupational therapy in the areas of psychiatry, physical disabilities, pediatrics, tuberculosis, occupational therapy in the hospital-school; job opportunities in occupational therapy.

OFFICERS

President	Jean Lovett, O.T.R.
Vice-President	Jean McNie, O.T.R.
Secretary-Treasurer	Mrs. Betty Lou Lacina, O.T.R.
News Editor	Harold Shalik, O.T.R.
Delegate	Maxine Ferrell, O.T.R.
Alternate Delegate	Jean McNie, O.T.R.

MISSOURI

Delegate-Reporter, Leonelle Gamble, O.T.R.

During 1952-53 the occupational therapists of Missouri through the legislative committee succeeded in changing job classifications in the State of Missouri Civil Service classification of occupational therapy positions and helped write up job specifications. As a result of this effort standards were improved, salaries increased and a new position of occupational therapy instructor was established. For example: staff therapist: old salary schedule, \$227-\$290 per month; new salary schedule, \$276-\$352 per month.

The research committee surveyed all the hospitals in Missouri for the following information: departments on the organization charts; if no department, was there interest in establishing one; qualified personnel on the staff; positions filled or vacant. A copy of *Minimum Standards for an Occupational Therapy Department* was sent to each hospital by publicity and recruitment. A follow-up on this survey will be extended into the coming year.

The combined efforts of the research and legislative committees will be spent working with the Civil Service Commission of the City of St. Louis in an attempt to raise salary scale and to improve the required examination for occupational therapists.

We plan a joint meeting with the Eastern Missouri Chapter of the American Physical Therapy Association, a continuing custom which was originated by the occupational therapists of Missouri.

Three years ago Missouri invited Tennessee to a meeting in St. Louis. In 1951-52, Tennessee entertained Arkansas and Missouri. Last year Missouri was again host to Tennessee as well as Arkansas and Kansas. As a result of these spring meetings an enlarged working relationship has been established with these states as well as an exchange of professional ideas among therapists.

OFFICERS

President	Theresa C. Burmeister, O.T.R.
Vice-President	Betty Bishop, O.T.R.
Secretary	Antoinette Yerkes, O. T. R.
Treasurer	Marian Stumpf, O.T.R.
Delegate	Leonelle Gamble, O.T.R.
Alternate Delegate	H. Dwyer Dundon, O.T.R.

NORTHERN CALIFORNIA

Delegate-Reporter, Louise Burton Wade, O.T.R.

During the 1952-53 year the Northern California Occupational Therapy Association has presented a varied program, in nine meetings, endeaoring to give its members professional information. In our joint meetings with the Northern California chapter of the American Physical Therapy Association we are working for always closer liaison with the physical therapists. A joint meeting with the Southern California Occupational Therapy Association was held which is always a stimulating exchange of ideas. With the 1955 conference coming closer we are solidifying our organization financially as well as physically and making plans for a memorable meeting in '55 in San Francisco, the city by the Golden Gate.

OFFICERS

President ....Mary D. Booth, O.T.R.
Vice-President ....Ethelyn Reimel, O.T.R.
Recording Secretary ....Evelyn W. Alexander, O.T.R.
Corresponding Secretary ..Ivabelle Rhodes, O.T.R.
Treasurer ....Earl Motta, O.T.R.
Delegate ....Louise B. Wade, O.T.R.
Alternate Delegate ....Eleanor Jean W. Daggett, O.T.R.

FELLOWS OF AOTA

Raymond B. Allen, M.D., Los Angeles, California.
F. H. Arestad, M.D., Chicago, Illinois.
Karl M. Bowman, M.D., San Francisco, California.
Sterling Bunnell, M.D., San Francisco, California.
A. B. C. Knudson, M.D., Washington, D. C.
Donald L. Rose, M.D., Kansas City, Kansas.

MEMBERS OF THE HOUSE OF DELEGATES

Speaker of the House............Marguerite Abbott O.T.R.
Vice-Speaker ....Mrs. Emiko Nishino, O.T.R.
Secretary ....Miriam Thompson, O.T.R.

July, 1951-*July*, 1954

Northern California
Mrs. Louise B. Wade, O.T.R.
559 Calderon St.
Mountain View, Calif.

Southern California
Miss Miriam Thompson, O.T.R.
5388 Village Green
Los Angeles, Calif.

Florida
Mrs. Pearl Tennyson, O.T.R.
2045 3rd Ave., N.
St. Petersburg, Fla.

Georgia
Miss Irene Perkins, O.T.R.
P. O. Box 271
Dublin, Ga.

Indiana
Miss Marian Kraker, O.T.R.
Sunnyside Sanatorium
Indianapolis, Ind.

Iowa
Miss Maxine Ferrell, O.T.R.
2320 33rd St.
Des Moines, Iowa.

Kentucky
Mrs. Berla Thomas, O.T.R.
Paoli Pike, Route 1
New Albany, Ind.

Maryland
Mrs. Eleanor S. Owen, O.T.R.
4001 Fordleigh Rd., Apt. D
Baltimore, Md.

Michigan
Miss Katherine Peabody, O.T.R.
Detroit Memorial Hospital
1420 St. Antoine St.
Detroit, Mich.

Northern New England
Miss Eileen Dixey, O.T.R.
N. H. State Hospital
Concord, N. H.

Pennsylvania
Mrs. Emiko Nishino, O.T.R.
University of Penn. Hospital
Philadelphia, Pa.

Wisconsin
Miss Norma Smith, O.T.R.
Milwaukee Children's Hospital
Milwaukee 3, Wis.

July, 1952-*July*, 1955 ..

Arkansas
Miss Virginia Stockwell, O.T.R.
2201 Main St., Apt. 7
Little Rock, Ark.

Connecticut
Miss June Sokolov, O.T.R.
Hartford County Workshop
680 Franklin Ave.
Hartford, Conn.

District of Columbia
Miss Althea Warner, O.T.R.
Fairlington Apts., A-2
4304 S. 34th St.
Arlington, Va.

Missouri
Miss Leonelle Gamble, O.T.R.
725 South Skinker Ave.
St. Louis, Mo.

New Jersey
Mrs. Gail Fidler, O.T.R.
930 Madison Ave.
Plainfield, N. J.

New York
Miss Marguerite Abbott, O.T.R.
5650 Netherlands Ave.
Riverdale, N. Y.

Oklahoma
No delegate appointed

Western Pennsylvania
Miss Marjorie Roth, O. T. R.
Mayview State Hospital
Mayview, Pa.

Tennessee
Mrs. Marion Beauchamp, O.T.R.
Occupational Therapy Dept.
Vanderbilt Univ. Hospital
Nashville, Tenn.

Texas
Miss Cornelia Ann Watson, O.T.R.
Occupational Therapy Dept.
Parkland Hospital, Dallas, Texas

Washington
Miss Shirley Bowing, O.T.R.
Occupational Therapy Dept.
College of Puget Sound
Tacoma, Wash.

July, 1953-*July*, 1956

Colorado
Miss Gayle Thelander, O.T.R.
4490 Teller Street
Wheat Ridge, Colo.

Hawaii
Capt. Jean Styles, O.T.R.
Occupational Therapy Section
Tripler General Hospital
Honolulu, Hawaii.

Illinois
Mrs. Elizabeth Jameson, O.T.R.
2325 S. 11th Ave.
Broadview, Ill.

Kansas
Miss Virginia Caskey, O.T.R.
V. A. Hospital
Excelsior Springs, Mo.

Massachusetts
Miss Marion Crampton
199 Bartlett Ave.
Arlington, Mass.

Minnesota
Miss Genevieve Anderson, O.T.R.
V. A. Hospital
54th St. and 48th Ave., S.
Minneapolis, Minn.

Western New York
Miss Eleanor Schreyer, O.T.R.
V. A. Hospital, Bailey Ave.
Buffalo, N. Y.

Ohio
Miss Mary McDonald, O.T.R.
Occupational Therapy Dept.
Columbus Receiving Hospital
Columbus, Ohio.

Oregon
Mrs. Janet Ranyard, O.T. R.
V. A. Hospital
Vancouver, Wash.

Puerto Rico
Mrs. Blanco P. de Coss, O.T.R.
Santa Patricio Housing Project
N-36-a Pueblo Viejo, P. R.

Virginia
Miss Ruth McDonald, O.T. R.
Occupational Therapy Dept.
Richmond Professional Institute
Richmond, Va.

Nebraska
Miss Sophia Lindahl, O. T. R.
Norfolk State Hospital
Norfolk, Nebraska

PRE-SCHOOL HEMIPLEGIC

(*Continued from page* 207)

(6) Abbott, Marguerite: "A Syllabus of Cerebral Palsy Treatment Technics," March, 1952.

(7) Doll, Eugene, and Walker, Mabelle: "Handedness of Cerebral Palsy Children," *Journal of Consulting Psychology*, Vol. 15, No. 1, February, 1951.

(8) Covalt, Donald, M.D., L. J. Yamshon, M.D., and Nowicki O.T.R.: "Physiological Aid to the Functional Training of the Hemiplegic Arm," *American Journal of Occupational Therapy*, Vol. 3, No. 6, Nov.-Dec., 1949.

(9) Gillette, Harriet, M.D.: "The Treatment of Cerebral Palsy," *The Physical Therapy Review*, Vol 32, No. 2, February, 1952.

(10) Gesell, A. and Ilg., F.: *Child Development*. Harper Brothers Publishers, New York, 1949.

PRACTICAL NURSE

(*Continued from page* 212)

ment period, the practical nurse has a better understanding of activities used in therapy and the effects of this type of treatment on the patient. The practical nurse also is made aware of the varied equipment and its use in therapy. Observing the patient in action has a positive effect on the practical nurse. It clarifies the value of this therapy, it reveals the abilities and capabilities of the patient and it vitalizes the role of the occupational therapist.

II. Practicum: craft instruction and analysis

Seven hours are devoted to craft instruction and analysis. Mimeographed material is issued to the group to simplify and clarify the craft process. An evaluation of each craft is made by the therapist to stress its value for different disabilities, for beneficial effects accrued, for possible u.e as a hobby interest and as a prevocational aid. Teaching or instructing in three minor crafts is the primary aim of this part of the syllabus. For it affords the practical nurse an opportunity to create and to learn new skills and techniques. In so doing, the student becomes aware of the enjoyment, the usefulness and the benefits derived from occupational therapy. It i interesting to note that during the craft instruction periods, the practical nurses were reluctant to leave even upon completion of projects but wanted to learn more skills.

III. Recreation

A discussion of recreational activities with emphasis on bibliotherapy is given by the librarian who is a member of the occupational therapy department. Stress is placed on the value of the library for patient therapy as well as music therapy which is an outstanding feature of this program.

IV. Group discussion

The students are requested to give written commentaries on the course. Basic questions such as (1) what does occupational therapy mean, (2) suggestions to improve the course and (3) criticisms of the course are suggested as a guide for their written comments. The results of these papers are proof of the effectiveness of this type of educational program. The practical nurses have only favorable criticisms of the course. It is one of the most interesting and enjoyable features of their training program. What they would suggest, however, is extended or increased allotment of time in occupational therapy and an opportunity to learn more of the skills so that they might be more useful in aiding the patient. They were very much impressed with the casual and informal atmosphere in the shop while learning these new skills and understand now why patients are so anxious to participate in occupational therapy activities. Because of this course, the practical nurses have a much better understanding of the meaning, the values and purposes of occupational therapy.

The benefits derived from this type of training program are manifold. On the part of the occupational therapy department it gives our therapists the chance to disseminate occupational therapy knowledge to a group concerned with the care of the patient throughout the day by (1) making occupational therapy more dynamic because of a

(*Continued on page* 238)

American Occupational Therapy Association

33 West 42nd Street, New York 36, N.Y.

Literature and Materials on Occupational Therapy

Free Distribution

1. Brochure—This is Occupational Therapy.
2. Personnel Policies for Occupational Therapists (for O.T.R.'s only).
3. List of Accredited Schools.
4. Guide for Training Occupational Therapy Volunteer Assistants (for O.T.R.'s only).
5. Career Brief on Occupational Therapy (pub. by Pratt Inst.)
6. Pre-O.T. Curriculum Guide for prospective O.T. students.
7. List of Literature and Materials on Occupational Therapy.

For Sale

1.	Bibliography for Geriatrics	$ .25
2.	American Journal of Occupational Therapy (yearly)	5.00
	(single copies)	1.00
3.	Army Technical Manual on O.T., TM8-291 (Rev. Sept. 1951)	.30
4.	Joan Chooses Occupational Therapy—Hudson and Cobb } Career Books	2.00
5.	Betty Blake, O.T.—Stern and Cobb } Career Books	2.00
6.	Hillhaven—Mary W. Thompson } Career Books	2.75
7.	Careers in Service to the Handicapped (Nat'l. Soc. for C.C.)	.50
8.	Colored Slides (32) on O.T. Trg.-U. of S. Cal. (free rental)	9.00
9.	Creed of Occupational Therapists	.10
10.	Occupational Brief No. 62	.10
11.	List of Films and Slides on Occupational Therapy	.30
12.	O.T. in Treatment of Tuberculous Patient—Hudson and Fish	3.00
13.	Burns—Discussions for O.T.'s and P.T.'s—Margaret Gleave	.50
14.	Equipment for an O.T. Dept. in a 200-bed Hospital	.25
15.	Prescribing Occupational Therapy—William R. Dunton, Jr.	3.00
16.	Curriculum Guide for Occupational Therapy (for clinical training and school directors only)	2.50
17.	Opportunities in O.T.—Marie L. Franciscus (Voc. Guid. Man.)	1.00
18.	Director's Guide (for clinical training and school directors only)	.75
19.	O.T. Insignia Plates—for use on stationery, etc.	3.00
20.	Planning the Complete O.T. Service—West & Clark	.50
21.	O.T. in the Rehabilitation of Surgical Cases—Helen Willard	.05
22.	Rural Handicrafts in U.S.	.35
23.	Principles of O.T.—Willard and Spackman, Editors	5.00
24.	Considerations in Muscle Function and Joint Measurement—Sue P. Hurt	.40
25.	Booklet of sample forms of referral sheets, progress records, and case study outlines for psychiatric occupational therapy	.75
26.	Proposed In-Service Training Program for Psychiatric Aides	.10
27.	OTR Gold Pins, 5/8" and 7/8" sizes	5.00 and 6.00
28.	Filmstrip "Occupational Therapy Unlimited." 35mm, b and w, 15" with script	1.00
29.	Filmstrip "O.T. Information Please," 35mm, band w, 12" with script	1.00
30.	Proposed In-Service Program for O.T. Aide in TB Hospital	.10
31.	Rehabilitation in the General Hospital—Dr. D. E. O'Reilly	.15
32.	Research—Duvall (A.J.O.T. reprint)	.15
33.	Occupational Therapy—Principles and Practice—Dunton and Licht, Editors	8.00
34.	Rater's Guide (for O.T.R.'s only)	.40
35.	Student Clinical Training Manual (for O.T. students and O.T.R.'s only)	1.10
36.	Manual on the Organization and Administration of O.T. Depts.	1.75
37.	Research in Psychiatric O.T.—Goodrich (A.J.O.T. reprint)	.15
38.	Your Future in Occupational Therapy (Milw. Journal reprint)	.35

Book Reviews

PSYCHOLOGICAL PROBLEMS OF CEREBRAL PALSY

A symposium sponsored by
American Psychological Association
and
The National Society for Crippled Children
and Adults, Inc.

1952 78 Pages

A brief discussion of the anatomical facts relating to spasticity was presented by Dr. Douglas Buchanan before the psychological discussions were given.

The psychological evaluation of the child with cerebral palsy was presented by Charles R. Strother, Ph.D., with emphasis on the many problems encountered in adequately testing and evaluating a child with cerebral palsy.

Harry V. Bice, Ph.D., discussed the value of group counseling for parents and presented some of the more common problems of parents with handicapped children.

The difference between neurophrenia and cerebral palsy was clearly defined in the paper by Edgar A. Doll, Ph.D., and ably discussed by Meyer A. Perlstein, M.D., who also briefly presented the sequence which occurs in cerebral palsy. Namely (1) etiology, (2) pathological changes, (3) clinical syndromes.

The need for more adequate educational and vocational planning for the cerebral palsied child was emphasized in the paper by T. Ernest Newland, Ph.D., along with the need for individualizing the cerebral palsied child. He suggested the emphasis on the child rather than the handicap.

All of these excellent articles were followed by an evaluation of the material weighed by capable and able discussants.

ADVANCING THE NATION'S HEALTH

National Health Council, N.Y.C., 1953 57 pp., 50 cents

An abridged publication of the opening and closing general sessions of the 33rd annual meeting of the National Health Council which was held in March in New York City.

The first session attempted to clarify the problems of health in America both immediate and long range. The final session attempted to point the way to the solution of these problems.

The proceedings interestingly present the ideas of national leaders in health problems and their constructive suggestions for future consideration.

ADD LIFE TO THEIR YEARS

Catherine Lee Walstrom
Published for
The Department of Social Welfare
National Council of the Churches of Christ in the U.S.A.

New York City, 1953 75 pages, $1.00

A manual prepared to aid staff, board members and volunteers to develop programs for older adults in homes for the aged. It is particularly written for the residences unable to employ an occupational therapist.

However it is excellent reading for occupational therapists planning to organize programs for older adults. The philosophy, the scope of the program and the discussion of the general problems encountered will make this a valuable addition to the occupational therapist's library.

QUIET WITHOUT RIOT

Published by
Wisconsin Heart Association
642 North Fifth Street
Milwaukee 3, Wisconsin

17 pages No charge

A booklet, published by the Wisconsin Heart Association and the Wisconsin Occupational Therapy Association, containing suggestions for making life in bed interesting.

Although written for the parents of children with rheumatic fever, the basic rules can be applied to any child who is sick. It is a type of material of exceeding value to parents who are suddenly confronted with a child who must be kept quiet in bed.

A typical daily schedule is included and activities are graded from mental games through the various degrees of hand and arm exercises.

The manuscript was prepared by Miss Norma Smith, O.T.R., Milwaukee Children's Hospital, and Mrs. Aileen Faulks, O.T.R., Milwaukee Curative Workshop. The Wisconsin Heart Association published the booklet and will handle its distribution.

EXPERIMENTAL STUDIES IN PSYCHIATRIC ART

E. Cunningham Dax
J. B. Lippincott Co.

1953 94 pages

As the title implies, the book discusses experiments in the relative value of painting and music on a limited number of psychotic patients. The book is of particular value because no assumptions are made. It presents some of the effects art may have upon the patients when they are ill and also the effects of mental illness upon creative ability.

"In painting, the results have been obtained from the study of the products of four years' work and the examples have been chosen from perhaps 20,000 pictures. In music, there has been very little opportunity for the study of the work of composers and if in this case the results appear to be suggestive, they are only individual findings."

The book is an attempt to justify the term "art therapy." The writer is sincerely experimenting with painting and music in order to develop the arts as a useful, scientific aid to psychiatric treatment. It is therefore a valuable study.

PROFESSIONAL EDUCATION BASED IN PRACTICE

Rosa Wessel and Goldie Basch Faith
University of Pennsylvania

1953

An evaluation of education in the field of social work which is of particular interest to occupational therapists because of the similarity of our educational problems.

The value of social work is successful person-to-person relationship. Therefore a successful social worker must have a good general education and a professional education which combines classroom and actual clinical experience. "Today our students learn, even in the classroom, out of their daily activity in the field."

Because the social worker's practice relates him to a client he will have to discover his own knowledge. No sharply defined rules can be proposed that are irrevocably true, rather "he will cumulatively develop an organized body of what in science and philosophy have been called the 'plausible' principles which can give both understanding, and form and structure for action but he will learn nothing that is infallibly true."

ONE HUNDRED AND SEVEN LEATHERCRAFT DESIGNS

1950 John W. Dean $2.00

CARVED BILLFOLD DESIGNS

1951 Raymond Cherry 31 pp., $1.00

GENERAL LEATHERCRAFT

1949 Raymond Cherry 124 pp., $1.50

Published by McKnight & McKnight

Three booklets available on leathercraft. Two are devoted entirely to patterns and design while *General Leathercraft* also includes instructions. The designs are typical of the patterns usually published in craft booklets. They are not particularly original or different but would be useful in a department where a variety of designs is needed and time does not allow the therapist to design his own.

O. T. DEPARTMENT

(*Continued from page 225*)

received 47,839 treatments in occupational therapy. Brooke is also one of the Army hospitals approved for occupational therapy training and therefore clinical affiliates from civilian schools, clinical affiliates from the army occupational therapy school and civilian students who take part of their training in the Army are assigned here. Of each class of enlisted technicians who have had eight weeks of didactic work, a number are assigned to Brooke for their four weeks of applicatory training before being assigned to duty.

The Medical Field Service School is the other large division of Brooke Army Medical Center. The Army's occupational therapy and physical therapy schools are there. The chief of the physical medicine service at Brooke Army Hospital is also director of the department of physical medicine at the school. The hospital staff does some teaching at the school and because of the close proximity of the two, all of the physical medicine clinics at the hospital are used for clinical demonstrations for students. Since all officers, both male and female, entering the Army Medical Service receive their basic training at MFSS and since courses of many kinds are continually being held at the school, tours of the clinics are frequent.

Because of the wealth of clinical material and the interest and enthusiasm of the people on the service, Brooke is "good duty" for army occupational therapists.

PRACTICAL NURSE

(*Continued from page 235*)

better understanding, (2) arousing interest in occupational therapy — its work, value, results, (3) giving the practical nurse some basic knowledge of simple handicrafts which could be relayed to the patient, (4) promotes departmental cooperation and integration, (5) possibly creating a hobby for the student nurse.

REPRINTS

Would you like a few copies of reprints but hesitate to send in your order because it is not large enough for a minimum order? If you would like a few copies, your order will be honored if enough orders are received to total the minimum order of 50 for an article. Orders must be placed before the 25th of the month of publication.

Number	Name of Article
....	....
....	....
....	....

Name ....

Address ....

CLASSIFIED ADVERTISING

Classified advertising accepted for POSITIONS WANTED and POSITIONS AVAILABLE only. Minimum rate $3.00 for 3 lines; each additional word ten cents. (Average 56 spaces per line). Copy deadline first of each month previous to publication.

POSITIONS AVAILABLE

Wanted: Occupational therapist for work in cerebral palsy treatment center. Good salary. Good working conditions. Scholarship available for additional training in cerebral palsy. Program directed by diplomate of the American Board of Physical Medicine. Write Herman L. Rudolph, M.D., 400 North Fifth Street, Reading, Pennsylvania.

Occupational Therapists for large psychiatric hospital located in New England. Progressive, all-inclusive program for patients. Student affiliations with excellent educational program. Modern home, good food. Maintenance optional. Liberal retirement plan and illness policy. Paid vacations and holidays. Write to Director of Occupational Therapy, Norwich State Hospital, Norwich, Connecticut.

Registered occupational therapist for psychiatric hospital. Start November, salary $309-379, maintenance available at $40. Write for particulars: Oregon State Hospital, Salem, Oregon.

Therapist for 250 bed chronic hospital. Expanding rehabilitation program with selected patients at Holy Ghost Hospital in Cambridge. Hours 8:00-4:30, 2-week vacation, salary $3,000. Inquire Dr. Brugsch, Medical Director, Rehabilitation Department, Boston Dispensary, 25 Bennett Street, Boston 11, Mass.

Occupational therapists for California public schools and state hospitals. New starting salaries $310 for recent graduates; $341 or $358 for one or more years' experience. Requires registration with national registry of qualified occupational therapists. Liberal vacation and retirement benefits. Write Dept. 0-12, State Personnel Board, 1015 L Street, Sacramento, California.

Occupational therapists wanted for large psychiatric hospital at Eloise, Michigan, near Detroit. Salary $4,177-$4,297, 40 hour week. Civil Service benefits, automatic annual salary increases, paid vacations and sick leave, membership in liberal retirement system. For information or application write to: Wayne County Civil Service Commission, 2200 Cadillac Tower, Detroit 26, Michigan.

Occupational therapist—registered—for tonic work with chronically ill. N.Y.O.T.A. personnel policy followed. Salary $3,267 for a 5 day week. Permanent. Apply or write Mrs. W. Shuff, Jewish Sanitarium & Hospital, 86 East 49th St., Brooklyn, N. Y.

Immediate opening: Registered occupational therapist for 350 bed tuberculosis hospital. Paid vacation, sick leave, retirement plan and uniform laundry. Staff occupational therapist positions available, also. Apply: State Tuberculosis Board, P.O. Box 286, Tallahassee, Florida.

Immediate opening for assistant occupational therapist. Well equipped out-patient center established 1951 offering nursery-school, occupational, speech and physical therapy to pre-school children. Beginning salary $3,200 if inexperienced, more if experienced. Five day week, four weeks summer vacation, ten day Christmas holiday. Write Miss Virginia Pettit, Director, Cerebral Palsy Center, 3601 Victory Parkway, Cincinnati, Ohio.

Wanted: Occupational therapist for poliomyelitis rehabilitation center in university teaching hospital. Write Harold N. Neu, M.D., Director, Poliomyelitis Rehabilitation Center, Creighton Memorial St. Joseph's Hospital, Omaha, Nebraska.

Interesting positions now open for qualified therapists in psychiatric training center. Paid sick leave, holidays, vacation. Salary open commensurate with experience and qualifications. Write Director of O.T., Central State Hospital, Norman, Oklahoma.

Wanted immediately: Occupational therapist for C. P. center in Eastern Virginia. Salary open, depending on experience and qualification. Apply at once Peninsula Cerebral Palsy Association, P.O. Box 371, Hampton, Virginia.

Widely known, brand-new, 500-bed research hospital, near Washington, D. C., starting progressive OT department. Integrated with entire treatment program. Accepting applications from OT's interested in working with physical disabilities (teaching activities of daily living) or planning recreation program for medical and psychiatric patients. Salary depends on qualifications. Minimum $3,400. Vacations, sick leave, retirement. Excellent opportunities for advancement. Send description of training and experience to Box OT-7, AJOT.

Fairfield State Hospital, Newtown, Conn. Occupational therapists and senior occupational therapists. $3,120-$4,620; 40-hour week; well-equipped working units; good living facilities; clinical training program.

Occupational therapist needed. Starting salary, $3,600.00. Therapist will have charge of her own department. Center is housed in new ranch styled building, and all supplies needed are furnished. Amarillo Cerebral Palsy Treatment Center, Inc., 808 Crockett St., Amarillo, Texas.

Registered occupational therapist for 255 bed tuberculosis hospital. Excellent rehabilitation program under full time coordinator of rehabilitation. Outstanding physical setup. Salary $325 plus vacation and holidays. Write to Superintendent, Tulare-Kings Counties Hospital, Springville, California.

Wanted: Director of occupational therapy for well established curative workshop in college town. Experience necessary, 5 day work week, salary open. For further details write Mrs. Rachel Wood, 183 Milford, East Lansing, Michigan.

Wanted: Registered occupational therapist for 120 bed sanatorium in North Carolina. Nice living quarters furnished, excellent working conditions with liberal paid vacation and sick time. Address Dr. M. D. Bonner, Supt. & Medical Director, Guilford County Sanatorium, Jamestown, N. C.

Occupational therapist wanted to work with cerebral palsied children. Sick days, hospitalization and two weeks vacation after one year. Minimum $3,600. Reply J. Patrick Thompson, Administrator, Carolina Spastics Assoc., Inc., 427 Wakefield Dr., Charlotte, N. C.

Immediate opening: Excellent opportunity for registered therapist. Progressive department with broad and varied activities including new children's program. Paid vacation, holidays, sick leave. Salary $3,580-$4,360, liberal increase first year, maintenance optional. Write to Personnel Officer, Caro State Hospital for Epileptics, Caro, Michigan.

Occupational therapist, beautiful 80-bed TB hospital. Salary approximately $3,000 plus meals, laundry, transportation. Give details, experience, recommendations first letter to Superintendent, Kimball Sanatorium, Battle Creek, Michigan.

Topeka State Hospital invites applications from men and women occupational therapists. Progressive program in all areas of psychiatry with national recognition. Excellent opportunity with vacation, sick and retirement benefits. Salary $3360 to $4980. Apply Personnel Officer, Topeka State Hospital, Topeka, Kansas.

Staff occupational therapist needed to work with psychiatric, medical, and orthopedic patients in a university teaching hospital. Apply: Director of Occupational Therapy, Duke Hospital, Durham, North Carolina.
